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Ontario

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence
for

SEPTEMBER 15, 1983

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Fowler (cont'd)

X Tobias

Soprinka

Lakana

Shanahan

Re-Ex Scott

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Pfister



ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Thursday, the 15th
day of September, 1983.

- - - - -


THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

- - - - -

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(Cont'd)



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	Lombardo (parents of deceased
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	Heather Dawson (mother of
	deceased child Amber Dawson)

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1
2
A/DM/ak ---Upon commencing at 10:00 a.m.

3 THE COMMISSIONER: Yes, Mr. Tobias.

4 MR. TOBIAS: Thank you,
5 Mr. Commissioner. Good morning.

6 DR. RODNEY S. FOWLER, Resumed

7 CROSS-EXAMINATION BY MR. TOBIAS: (Continued)

8 Q. Dr. Fowler, yesterday you
9 indicated that you would, over the evening, try to
10 ascertain the date of your meeting with Mr. and Mrs.
11 Hines, and the meeting with them in Mr. Sneddon's
12 office, have you been able to find that page?

13 A. It is Mr. Sneddon's office,
14 the Superintendent of the Hospital and I went through
15 my diaries and that was July the 7th, in his office,
16 1982 at 5 o'clock.

17 Q. Now I am curious about one
18 aspect of the meeting. I believe you told me yester-
19 day, and correct me if I am wrong, that at the time
20 of the meeting you were aware of dig. levels that had
21 been taken in Jordan Hines, but I wasn't clear as to
22 whether you were aware of the precise levels that had
23 been obtained, or only that there were levels and
24 they were high. Do you recall that evidence?

25 A. Yes, and I am not sure whether
I actually have the document that said what they were,



1
2 or if I had just heard that the levels were high.
3 Because of course I think by this time the parents
4 had been told by the coroner's office that it was
5 conceivable that the child had been given an overdose,
6 and this was their concern of course to discuss with
7 us this information. I am not sure how I knew that
8 and whether I had the precise levels and so on, but
9 I knew at the time of that meeting that digoxin
10 intoxication was possible.

11 Q. Perhaps I can assist you in
12 terms of helping you recall more precisely the exact
13 nature of your knowledge of the dig. readings. July
14 of 1982 I believe would have been after the conclusion
15 of the Preliminary Inquiry in the case of Regina
16 versus Nelles, is that not correct?

17 A. I am not sure.

18 Q. All right. If you were to
19 be told that it was following the Preliminary Inquiry,
20 after the Inquiry had been completed.

21 A. Yes.

22 Q. Would that assist you at all
23 in helping you to be more precise in terms of the
24 exact extent of your knowledge of those dig. levels?

25 A. Yes. That may be the reason
that I knew that they were elevated, but I must



1

2

confess that I didn't read the whole transcript of
that whole Inquiry.

3

4

Q. Did you give evidence at that
Inquiry yourself?

5

6

A. Yes.

7

8

9

Q. And I take it that obviously
those children who died in March of 1981 when you
were ward chief would have had some special interest
for you personally?

10

A. Yes.

11

12

13

14

15

16

17

Q. And I would also take it,
and correct me if I am wrong, that with respect to
the evidence going in at the Preliminary Inquiry
regarding the methodology of obtaining dig. levels
and the dig. levels themselves, you would have had
particular interest in whatever evidence was adduced
regarding those children who died in March. Am I
also correct in that assumption?

18

19

20

A. Yes, I was interested, but as
I say I didn't read every word of the Preliminary
Inquiry.

21

22

23

24

25

Q. Surely, however, Doctor, you
must have discussed the evidence being adduced at
those preliminary hearings with your colleagues?

A. Yes.



1

2

3

Q. And I would imagine you
discussed it in more than a casual manner?

4

A. Yes.

5

6

7

Q. Do you recall discussions
around the time of the Preliminary Hearing with your
colleagues specifically regarding dig. levels obtained
on Jordan Hines?

8

9

10

11

A. No, I don't, I may well have
discussed it with them but I don't remember a
specific discussion with a specific colleague about
it.

12

13

14

Q. Was there any time, sir, that
the Crown Attorney or the police specifically shared
that information with you, did you have any discussions
with them?

15

16

A. I may well have done so.

17

Q. On the results of the tests.

18

19

20

21

A. It was - I may have talked to
them about that and you may have evidence that I did
discuss that with them. It is quite conceivable
that we did go over them, but I don't remember the
specifics.

22

23

24

25

Q. Now as well we have had filed
as exhibits, both at this Inquiry and I believe in
the Preliminary Inquiry, certain test results



1

2

published by the Centre of Forensic Sciences on
specific testing?

4

A. Yes.

5

6

Q. Had you at the time of the
Preliminary Inquiry seen those documents, had you
read them?

7

8

A. I don't think I had read
them, no.

9

10

11

12

13

14

15

Q. Is it fair to say, however,
Doctor, that given the fact that that meeting was
after the Preliminary Inquiry, and after some of your
ongoing discussions, is it fair to say that in all
probability your understanding of what those dig.
levels were was probably more specific than you
thought yesterday, is that a fair statement?

16

17

18

19

20

A. No, I don't think that is
a fair statement. All I can remember of that inter-
view with the Hines parents was that I was aware of
the fact that digitalis levels were high, and I was
discussing that along with the other differential
in this child's death.

21

22

23

24

25

Q. All right. I won't ask you
when you were first advised that digitalis had been
found in tissue of Jordan Hines. I will ask you this,
you were aware of the fact that Jordan Hines had not



1

2

been prescribed digoxin.

3

A. Well, yes, I was aware of that.

4

Q. You were also aware of the

5

fact that according to the medical records digoxin

6

had at no time ever in the child's life, other than

7

perhaps maybe when he was at home and not in Hospital

8

being monitored, had never been administered to him.

9

A. I was not aware of it being

10

given to him, but I naturally haven't got all the

information of his previous ---

11

Q. You knew it had not been

12

given, or it shouldn't have been given at the Hospital

13

for Sick Children?

14

A. That is true.

15

Q. And you knew it wasn't

16

prescribed. You also knew, you are telling me at

17

the time of that meeting that you knew that digitalis

had been found and the readings were fairly high.

18

A. Yes.

19

Q. What was your reaction when

20

you found that out?

21

A. I thought digoxin could have

22

been related to the child's death.

23

Q. And were you suspicious under

24

those circumstances?

25



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A. I was - no, that's just simply one of the causes, but I think the weight of evidence in my review of that chart and other people's review was that he had another disease, a disease that could easily have caused his death. I pointed this out to the parents that there still was a question as to what the cause of his death was.

Q. Is it not fair to say though, Doctor, that after you found out about the dig. levels that you were somewhat less satisfied with the SIDS explanation than you were before you found that out?

A. Yes. Well, no, I think that that is just another - that is just another cause of this child's death.

Q. Well, Doctor, let's be logical about it.

A. Yes.

Q. If in the absence of any dig levels in the child at all.

A. Yes.

Q. If we could assume that there were no dig. levels found.

A. Yes.

Q. And there were no reason to



1

2

even consider the question of digoxin.

3

A. Yes.

4

Q. Then obviously after a fairly

5

lengthy and detailed review ---

6

A. Yes.

7

Q. You would have been able to

8

rest assured that you had eliminated all other possibilities other than SIDS, is that not so?

9

A. No, I would have thought that

10

SIDS was the likely explanation for the boy's death,

11

and then with this other evidence of the digoxin,

12

then that brings up a question. But naturally as our

13

knowledge of the pharmacology of digoxin has increased,

14

the importance that we can put on that particular

15

laboratory finding is less important, it hasn't

16

nearly as much weight now as it even did at that time.

17

Q. Doctor, I want to be fair, but

18

let's cover this very carefully. Is it fair to say

19

that, leaving aside the consideration of digoxin,

20

in your opinion on the basis of all the information

21

presented to you, there was no other possible cause

22

of death of a parallel significance as SIDS, is that fair to say?

23

A. I would say that this child

24

25



1

2

most likely died of SIDS if we didn't have this
other information.

3

4

Q. Precisely, that would have
been your conclusion on the basis of all the evidence
available to you?

5

6

7

A. Yes.

8

9

10

11

Q. It was the discovery of dig.
levels that made you question the SIDS theory, was it
not? Because that gave you another alternative,
another possible explanation that hadn't been ruled
out?

12

A. That is another explanation.

13

14

15

16

Q. Therefore is it not fair to
say, as I said a few moments ago, that after the
information came to you you had to be somewhat less
sure of the SIDS diagnosis than you were before the
information came to you?

17

A. Yes, that's true.

18

19

20

21

Q. And that is what caused you
to question it was the introduction of that new
piece of evidence that you were previously unaware
of?

22

A. Yes.

23

24

25

Q. That in fact dig. levels
had been found?



1

2

A. Yes.

3

Q. Also you were indicating

4

yesterday, just before the break, that overnight you

5

would attempt to have a look at the chart of Jordan

6

Hines?

7

A. Yes.

8

Q. And any other records available

9

to you, in order to determine whether in fact there

10

had been an episode of mouth to mouth resuscitation

11

at home. Have you been able to find any reference

in the material to that event?

12

A. No, there wasn't, but the

13

child had three or four episodes that I am sure have

14

been outlined in great detail here in this Court

15

before, and the child stopped breathing and the

16

mother didn't do mouth to mouth resuscitation, but

17

she picked the child up and shook it each time to

18

bring him around and he immediately became pink

again. I understand that this occurred on several

19

occasions, three or four.

20

Q. My information, Doctor, and

21

I am relying on the notes of the North York General

22

is that there was one occasion at home of apnea,

23

and several occasions in North York General Hospital

of apnea.

24

25



1

2

A. Yes.

3

Q. And we have the medical records

4

from the Sick Children's Hospital that there were

5

apneic periods in the Sick Kid's Hospital as well.

6

A. Yes.

7

Q. Are you aware of any other

8

occasion prior to March 8th, 1981, where the child
had to be resuscitated?

9

A. No.

10

THE COMMISSIONER: I'm sorry I didn't

11

understand, you say there was how many occasions did

12

the child ---

13

THE WITNESS: My understanding was ---

14

THE COMMISSIONER: There was one

15

case in the crib at home.

16

THE WITNESS: I understood that

17

there were more cases than that, but they may have

18

occurred in the other hospital. On the admitting

19

note to our Hospital I had a note that he had had

20

MR. TOBIAS: Q. Can you direct me

21

to which page of the medical record, Doctor, the

22

admitting note appears at?

23

THE COMMISSIONER: Apneic is a

24

lack of breath, isn't it? Is that a total loss of

25



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breath?

THE WITNESS: Well, yes, you stop breathing for a certain number of seconds and that is called apnea, you stop breathing for various lengths of time.

THE COMMISSIONER: What I am getting at is that an indication of the Sudden Infant Death Syndrome?

THE WITNESS: Yes, it is a very suggestive point.

THE COMMISSIONER: But that apnea, all adults can suffer from that, can they not?

THE WITNESS: Oh, yes, yes, there are many, many causes for stopping breathing and the-of course it has all sorts of other physiological effects when you stop breathing your heart rate, various things happen.

Q. Doctor, were you referring perhaps to page 55 of the medical record of Jordan Hines, which appears to be the Emergency Department notes from the Hospital for Sick Children and there is recorded a history of the child?

THE COMMISSIONER: And the page?

THE WITNESS: 58 is it?

MR. TOBIAS: Page 55 of Exhibit 103.



1

2

THE COMMISSIONER: Page 55?

3

MR. TOBIAS: I'm sorry, page 58,

4

my copy is not numbered all that well.

5

Q. Page 58 of the medical record.

6

A. Yes, this is where it came

7

from a:

8

"17-day old infant who had a gray/blue

9

spell with choking and was picked up

10

and rapidly became pink again and this

11

occurred three to four times not

related to feeding."

12

Q. Now, three to four times would

13

refer to the total number of times at home and at

14

the North York General Hospital, would it not?

15

A. I am not sure, I didn't write

16

the note. I am not sure whether that means at home

17

or in the other hospital and at home, but it says

three to four times.

18

Q. In fact the only people I

19

suppose who could help us with that would be the

20

Hines themselves?

21

A. Yes, to say whether it actually

22

did happen any other time at home.

23

THE COMMISSIONER: I think it will

24

be good to avoid some sort of reply evidence, if you

25



1
2 have information to the contrary to put it to him,
3 that's all, if you have, if you haven't.

4 MR. TOBIAS: Well I have in fact
5 put it to him. My information is that it did happen
6 once at home. I asked him a few minutes ago whether
7 he agreed with that and he couldn't recall. I believe
8 that was the exchange, Doctor.

9 THE COMMISSIONER: What about the
10 three to four times, have you information that is not
11 correct?

12 MR. TOBIAS: No, I don't have
13 information that is not correct. I have information
14 that there was only one episode at home and there
15 may have been other incidents at North York General.

16 THE COMMISSIONER: Yes, all right.

17 MR. TOBIAS: Q. Now, Dr. Fowler,
18 I believe when we stopped yesterday I had asked you
19 to take me through the factors which helped convince
20 you that SIDS was the likely cause, both with respect
21 to the infant's history and his pathology. We talked
22 at length about the information that Dr. Bain had
23 available to him. The information that Dr. Becker
24 had available to him. You told me you were relying
25 on the opinion of Dr. Bain, Dr. Rowe and Dr. Becker?

A. Yes.



1
2
3 Q. Then you told me those things
4 that you thought particularly significant in the
5 child's history that explained why you were convinced
6 that SIDS was the likely explanation in this particular
case.

7 Now, I asked you yesterday, but I
8 will ask you again since you may have had some time
9 to consider it overnight, was there anything that
10 we didn't discuss yesterday that you feel is
11 significant to the conclusion that you have drawn?
12 Are there any other factors you want to bring to my
13 attention as to why you feel SIDS is the likely cause
of death?

14 A. No, I don't think I have other
15 factors.

16 Q. Now, it is clear from the
17 record and from both our discussion of yesterday
18 and my discussions with Dr. Rowe when he was giving
19 evidence, that as far as Dr. Becker's concern SIDS
20 was a possibility and it merited further considera-
21 tion and that is why he wanted to do microscopic
studies of the conducting system?

22 A. Yes.

23 Q. It is also clear from reading
24 the Bain report and from what Dr. Rowe has told me,
25



1

2

3

4

5

and from what you have told me, that Dr. Bain didn't share that reservation of Dr. Becker, he was more prepared than Dr. Becker to point the finger to SIDS and say that was the likely cause?

6

A. Yes.

7

8

9

10

Q. All right. Now we obviously, he obviously had a difference of opinion. I am asking you whether you can help me at all or assist me in resolving the apparent conflict between those two views, is there any way to resolve it?

11

12

A. I don't really understand that there is a conflict.

13

14

15

Q. All right, perhaps you can explain to me your views on whether or not there is a conflict?

16

17

18

19

20

21

22

23

24

25

A. Well, I think that Dr. Bain felt assessing all the chart that SIDS was the likely cause of death; and that Dr. Becker said that there were lots of pathology findings pointing to SIDS. The only thing that disturbed him was the fact that there had been some arrhythmia, the tachy/bradycardia that he wondered if that was characteristic of SIDS, and in actual fact there have been some cases reported in which that occurred in the missed-SIDS.



BmE.jc

B

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Q. You agree with me that those cases though are very rare and occur in only a small percentage of cases?

A. If they occur once it's possible.

Q. Okay, I agree with that. You also agree with me that something particularly characteristic of those type of arrhythmias, as traced on the ECG, are a prolonged QT interval. I believe you gave Mr. Lamek some evidence regarding that?

A. I think that there are a few cases of the prolonged QT interval but on further analysis into the families and so on I think that the majority of people who, and I am not an expert on SIDS and I haven't read all the literature, but I understand that many people feel that the long QT interval is not nearly as important as it had been suggested by certain authors.

Q. In any event, Doctor, the point is this: Dr. Becker clearly was concerned with the presence of arrhythmias?

A. Yes.

Q. And was concerned enough to say that he needed further investigation and SIDS was only a possibility. Dr. Bain obviously didn't



B.2

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2

share that concern and that reservation. Do you

3

agree with that?

4

A. Yes, I think that's true.

5

Q. And to that extent the two

6

opinions are not in agreement?

7

A. But I think that the impact of

8

Dr. Becker's report is that SIDS is likely the
explanation.

9

Q. All right. I am told, and I

10

have been told several times now, that Dr. Becker is

11

somewhat of a world renowned expert in the field of
SIDS?

12

A. Yes.

13

Q. Would you share that view?

14

A. Yes. I'm told that, I wouldn't

15

be able to say for sure but I'm told that he is.

16

Q. Well, I understand that he's

17

done extensive writing on the subject and investigation

18

into the subject, is that also not correct?

19

A. That's true.

20

Q. All right. Now, I realise that

21

Dr. Bain as well is a world renowned expert on
paediatrics?

22

MR. SCOTT: He's a world renowned

23

expert on SIDS as a matter of fact, and was chairman

24

of the latest conference on the subject.

25



B.3

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MR. TOBIAS: I was about to come to that. My friend checks me before I get the chance to put the question to the witness.

MR. SCOTT: I'm sorry.

MR. TOBIAS: Q. Can you tell me, can you advise me of Dr. Bain's specific background? Tell me what teaching he's done in the area, what articles he has published?

THE COMMISSIONER: Well, we were having Dr. Bain at some point?

MR. LAMEK: Yes.

THE COMMISSIONER: This is remotely relevant because perhaps it goes to the validity of his opinion but surely we would rather have Dr. Bain. If he is relying on Dr. Bain's opinion we would rather have it from Dr. Bain I think.

MR. TOBIAS: I'm quite content to put the question to Dr. Bain. I think I can conclude this area by simply asking this question. You showed no reluctance yesterday in ranking those factors that led you to the conclusion that SIDS was the likely cause and I believe, please correct me if I'm wrong because I don't have it marked in the transcript, I believe the ranking was that you said Dr. Bain's opinion, Dr. Rowe's opinion --



B.4

1

2

A. Yes.

3

Q. -- and Dr. Becker's opinion?

4

A. Yes.

5

Q. Is that correct?

6

A. Yes, I felt that ...

7

Q. All right. Would you agree with

8

me, is it a fact that in this particular case you are
putting more stock into Bain's opinion and you have a

9

little bit more faith in it. Is that a fair statement?

10

THE COMMISSIONER: Than the others is

11

what he is saying.

12

MR. TOBIAS: Well then, Becker's in

13

particular.

14

THE COMMISSIONER: Yes, that's what

15

he has said.

16

A. Yes, I ranked them and I still

17

rank them in that way. It is not entirely their
opinion, I am bowing to their experience and skill in

18

this area which I am not skilled in but I also have

19

reviewed the record myself, being a paediatrician, and

20

find it consistent and that I think for this reason

21

the experts' and my own reading of the record that I

22

think this is the likely explanation and I think that

23

it should all be left to the pharmacologists because

24

I think they have to come up with a real hard evidence

25



B. 5

1

2

that this child actually had real digitalis in his
body when he was exhumed.

3

4

Q All right. Now, Dr. Fowler,
you are aware of the fact that the preliminary
autopsy report showed no evidence of infection?

5

6

A. Yes.

7

Q In Jordan Hines?

8

A. Yes.

9

Q And I suppose that, although
that particular observation on the preliminary autopsy
report didn't rule out Dr. Rowe's theory of a virus
affecting the heart muscle, later investigation did
rule that theory out and that theory was ultimately
put to rest?

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A. Yes. I think when we are
talking about an infection in the heart muscle, in
other words myocarditis, I think that it was finally
decided that this was not the explanation for the
child's death.

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Q All right. Now, in the cross-
examination of Dr. Rowe, we discussed several factors
that could have caused the death.

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A. Yes.

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Q And we discussed several
possible causes of death that at one time or another

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were considered. We went through them and came to the conclusion, I am sure that you are familiar with that evidence if you have read the transcript?

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A. Yes.

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Q. That on the basis of the information we have today Dr. Rowe was satisfied that the two causes still under consideration are digitalis intoxication?

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A. Yes.

Q. Or SIDS. Or perhaps some other

unknown factor that we don't even know about?

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A. Yes.

Q. Would you agree with that or are

you ---

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MR. SCOTT: Is there a page number for that just so that we will have it on the record?

MR. TOBIAS: I do not have the precise

page number.

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MR. SCOTT: All right.

MR. TOBIAS: Q. Are you satisfied

with that evidence, do you agree with it?

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A. Yes. You are talking about SIDS, digitalis intoxication or some other condition unknown at the moment. But we are just mentioning those, we are not ranking them.



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Q. No.

A. If you want to rank them in terms of how important you think they should be, that's something else, but you are simply saying that those are three methods of the cause of death in this child.

Q. I understand.

A. And I would agree with that.

MR. SCOTT: Mr. Commissioner, I hate to keep doing this but that is not my recollection of Dr. Rowe's evidence, which was that contemporaneously SIDS was regarded I think as the appropriate explanation. He went on to say at the end that if there was a murderer in the Hospital who administered directly digoxin to children of the murderer's selection you couldn't exclude Hines from the category because there was digitalis there according to the exhumed report.

MR. TOBIAS: I think that Mr. Scott ---

MR. SCOTT: That's not quite what my friend said.

MR. TOBIAS: Mr. Scott may be correctly summarizing Dr. Rowe's evidence in chief to Mr. Lamek though, although, I'm not sure that I completely agree with that synopsis either. But what I'm



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2 referring to was these particular series of questions
3 that I put to him in cross-examination wherein I listed
4 all of the possible suspected causes that at one time
5 or another were considered and I believe my recollec-
6 tion of the evidence is correct. I will attempt to
7 find the specific reference later in the day.

8 MR. SCOTT: Well, can we simply
9 leave it and go on. I don't want to make a point
10 about it as my friend doesn't have the page number,
11 but it is helpful to have the page number and we can
12 check these things as we go along.

13 MR. TOBIAS: All right. Well, I will
14 attempt later in the day to come up with the page
15 number so that we could put it into the record.

16 In any event, the only point really
17 that I am addressing myself to at this time is Dr.
18 Fowler's own state of mind at this time about what
19 causes still are outstanding or may possibly explain
20 the death and I think he has done that adequately.

21 I was about, Mr. Commissioner, to
22 move into a fresh area. My friend, Mr. Sopinka, has
23 indicated that he has a very short cross-examination
24 which may last one half hour or less and he has other
25 engagements in other courts this morning that require
his attendance. This may be an appropriate place



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for me to break and allow Mr. Sopinka to conduct his
cross-examination and then I can resume.

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THE COMMISSIONER: Yes, all right.

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MR. TOBIAS: I assume Mr. Scott has

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no objections to that?

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MR. SCOTT: No.

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THE COMMISSIONER: Well, I see

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Mr. Percival is coming in, so, I think he should be
present perhaps during the cross-examination so that
he can make the appropriate noises.

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MR. SOPINKA: He has been making

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inappropriate noises and that's why I'm here.

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THE COMMISSIONER: What about this

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question of the statement, have you seen that?

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MR. SOPINKA: Mr. Commissioner, I have

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two short matters. One is a brief cross-examination

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with respect to one point raised by Mr. Percival but,

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more importantly, I am here to serve notice of motion

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that I take objection to the direction that the

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inquiry is taking insofar as Mr. Percival's partici-

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pation is concerned.

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What I am concerned about is the

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evidence at the preliminary hearing which was given

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in camera is now being trotted out.

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THE COMMISSIONER: It is not in camera

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any more though; it is public, it is not in camera.

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MR. SOPINKA: Yes, I appreciate that, but I am saying that evidence was heard in camera and Susan Nelles was discharged at the preliminary hearing.

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In connection with Phase 1, my friend is really conducting Phase 2.

Now, as I read the Order-in-Council there are two phases, as you have ruled. The first one requires you to determine how the children came to their death but without determining who caused their death.

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THE COMMISSIONER: That's not quite what it says. It says without ---

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MR. SOPINKA: Well, it doesn't say that but the statement of the Attorney General certainly said that.

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THE COMMISSIONER: No, no, it is right in the - if you look at the - and some day I am going to have an argument on just what that does mean but that is not quite what it says. I have read it about 28 times.

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MR. SOPINKA: It uses the very language from the Coroner's Act.

THE COMMISSIONER: Yes, that's right, I understand that.



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MR. SOPINKA: --- blame is not to be

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assessed.

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THE COMMISSIONER: Well, it is not as

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simple as that. What it does say is without

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expressing any conclusion of law regarding civil or

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criminal responsibility. Now, those are the precise
words and those are the ones we have to deal with.

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MR. SOPINKA: Well, in any event, it

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is my submission, and you may not agree with me, but

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it is my submission that it is no part of this Inquiry

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to try a charge and in fact the Province would have

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no constitutional power to order an inquiry and it is

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really the trial of a charge and I have some

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authorities.

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THE COMMISSIONER: No, no, I am asked

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to determine the cause of death and to determine the

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cause of death it may be necessary to go into the --

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because if one of the theories certainly is a theory
of intentional massive overdose of digoxin, there has

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to be someone to do that. If it is impossible for

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anyone to have done it, that is certainly relevant

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and it is certainly relevant to consider I would think;

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I would think. I don't want to argue the question now.

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MR. SOPINKA: Well, that is not,

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Mr. Commissioner, with the greatest of respect, that's

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not Mr. Percival's object. I mean, to say specifically who showed grief and who didn't show grief, if grief was not shown by some and insofar as supporting the murder or non-murder theory, that's as far as you need go and that is as far as the Attorney General went in his examination and then Mr. Percival comes in and he really is leading evidence directly from the preliminary hearing and the only purpose of that was to prosecute Susan Nelles.

With the greatest of respect, he is conducting, I submit, Phase 2 in Phase 1 and he is not doing it right because in my submission what Phase 2 is, it is an inquiry into the conduct of the police, not an inquiry into the conduct of Susan Nelles.

THE COMMISSIONER: No, but Phase 1 is an inquiry into the death of the children. There may be some point where it becomes so remote that it is not relevant and I won't put it in. But surely appearing at - and I don't say how much weight you give to it, if you give any weight to it at all.

MR. SOPINKA: Well, you may not give it weight but the newspapers will certainly give it a lot of weight.

THE COMMISSIONER: Well, I can't help that. It is a public inquiry, I can't tell them what



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they are to give weight to and what they aren't. I can tell myself what to give weight to or you can tell me and I may or may not follow it. I can't do much about that. It is a public inquiry, that's what the government wanted. If they want to draw conclusions, if the evidence is relevant, surely I have to receive it.

MR. SOPINKA: Well, what is left for Phase 2 if my friend leads all the evidence there is except for the police?

THE COMMISSIONER: Well, exactly what it says.

MR. SOPINKA: In my submission what this Order-in-Council contemplated was that when you came to deal with what evidence there was against Susan Nelles the police would have to justify their conduct in investigation and laying the charges.

THE COMMISSIONER: That's right.

MR. SOPINKA: My friend has got the whole thing reversed. He's now going to conduct a sniping prosecution of Susan Nelles. Every day we're going to read in the headlines when he trots in here that some old piece of evidence that was rejected ---

THE COMMISSIONER: Before you get too excited, this is the very first question that was



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2 put with regard to this, at least as I remember, with
3 regard to ---

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MR. SOPINKA: Well, no, but that is
5 the way it is leading. It is not the first question,
6 he asked a question about who recommended setting up
I.V. units.

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THE COMMISSIONER: That's right,
8 you're quite right, it is the second question. It is
9 not something that is going on every day.

10

I would have thought, I am prepared
11 to have argument if you insist upon it as to whether
12 we can or cannot deal with that in Part 1, but it
13 does seem to me that it has some relevance to the
issue of the cause of death.

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MR. SOPINKA: Well, I appreciate you
15 have made that ruling. I submit with respect, and
16 this is really only intended as giving notice to
17 other counsel because I told Mr. Percival I was
18 going to do this this morning, but they may not have
19 known, I think that this should be argued because
20 what is going to happen is every day if this continues
21 the public is going to be reading that Susan did this
22 or Susan did that and they apply to others as well.
23 Three months down the road Susan Nelles will be
allowed to testify.

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Now, if we want to have Phase 2 I'm quite prepared right now to have the Police here and I'm prepared to produce Susan Nelles and let's have it out now instead of having this sniping prosecution. I mean, she has gone through one already and that's enough for most people.

THE COMMISSIONER: Yes, all right.

MR. SOPINKA: And in my submission if this is going to continue I submit either we get into Phase 2 now and let's have it over with or else you should stop Mr. Percival and if you're not content to do that I am going to ask you to state a case to the Divisional Court under Section 6.

Now, a less serious motion is, I would like to have the right to inspect the police report because one of the reasons why Mr. Percival is being able to ---

THE COMMISSIONER: Well, I don't think you need to argue that at the moment, I'm on your side. It's an old fashioned rule, don't talk if you're about to win.

MR. SOPINKA: I'm just asking it at the moment.

THE COMMISSIONER: I think the other one you have a good deal of merit in your argument,



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that is, a good deal of merit in argument - I don't
say there's a good deal of merit in your argument.

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I made the ruling so far as that
question is concerned. I probably will deal with it
from time to time. So far as the stated case is
concerned I don't ---

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MR. SOPINKA: Well, I think that
should wait for your decision and that should await
an argument, a fuller argument on the point that I
have raised.

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THE COMMISSIONER: Well, I am quite
happy to take time off, or some separate time for an
argument on that question, but you are making, it
seems to me, a terrible mountain out of what is a
relative molehill. As I say, there have been two
questions so far. These questions are bound to come
out when your client, if your client does give
evidence, it is bound to come out under those
conditions.

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MR. SOPINKA: Oh, yes, she will be
able to explain them then.

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THE COMMISSIONER: Well, that's right.
MR. SOPINKA: And instead of in the
newspapers you are seeing Mr. Percival ---

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THE COMMISSIONER: But you will be



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2 asking her those questions yourself if nobody else
3 asks them about an explanation of that. How can you
4 pretend it hasn't anything to do with the cause of
5 death? If you are going to bring out the evidence
6 yourself in this phase ---

7 MR. SOPINKA: No, I didn't even know
8 she would be called in this phase, I haven't been
9 told that.

10 THE COMMISSIONER: Well, I am going
11 to anticipate this but I would think it is probable.

12 MR. SOPINKA: I wouldn't be asking
13 those questions for the purpose of leading evidence
14 relating to the first phase, I would have thought
15 it would have some relevance because obviously the
16 Police will be saying what evidence they had and
17 I would be calling her to refute that.

18 THE COMMISSIONER: It might be
19 relevant. Unfortunately it could easily be relevant
20 to both and, if that is so, I don't want, when we
21 come to the end of this, I don't want someone to say
22 that we haven't had all the evidence that relates
23 to the cause of death and I don't want it coming out
24 in the second phase because there will be some counsel
25 who probably will not have standing in the second
phase. I don't expect you to be one of them but ...



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MR. SOPINKA: I appreciate the problem that you see, but I submit that there is a way of separating how the children came to their death and who did it. There has to be because in my respectful submission the law is very clear that it is very unfair, and in this case it is doubly unfair to have a Royal Commission where the rules of evidence are not observed, it is all in public, to be tried, especially a second time, and it is a very serious motion. I don't want to sound acrimonious about it, but I mean, I would like an opportunity to argue it more fully and before Mr. Percival drops his next gem.

MR. PERCIVAL: I didn't realize it was jewellery.

MR. SCOTT: Mr. Commissioner, can I say something if Mr. Sopinka is finished?

THE COMMISSIONER: Well, I don't know that he is, but perhaps he is. Is that all you want to say for the moment?

MR. SOPINKA: That's all I want to say and then I have a 10-minute cross-examination.

THE COMMISSIONER: Yes, all right.

MR. SCOTT: I have nothing to say about the stated case except that every lawyer has suppressed heaves with anticipation at the possibility



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of getting our gowns on again.

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On the second point ---

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THE COMMISSIONER: On a Friday I
assure you.

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MR. SCOTT: On the second point I
join with Mr. Sopinka. Let me focus it this way.
Elaborate precautions have been taken by the Commission
with the consent of some people over the objection
of others to prevent Chapter 8, or whatever it is,
of the Atlanta Report, from being released to anybody
in the public domain. The motives for that and the
purpose of it have been canvassed and are there.

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THE COMMISSIONER: It is possible, I
am thinking out loud, but it is possible that it might
be arranged that these questions could come out at
a later date. It would take a great many people a
great many hours of argument to persuade me they're
not relevant. It is certainly more convenient while
Dr. Fowler is here that he be asked that question,
if he is going to be asked it at all.

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MR. SCOTT: In the end, all the
questions that anybody wants to ask are going to be
asked.

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THE COMMISSIONER: That's right.

MR. SCOTT: If we survive the exercise.



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But the point is that with respect to the Atlanta

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Report, the publication of which I have been seeking

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for some time, it has been decided by the Commission

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that in fairness it should not be released until we

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come to the stage when the evidence on which it is

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based is tendered.

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THE COMMISSIONER: That's right.

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MR. SCOTT: Now, it seems to me with the greatest respect that the phasing of the Inquiry was designed to assure that that would be done with respect to the matters that were under investigation by the police.

Now I have no personal interest in the questions that Mr. Percival asks, I didn't object to them, but that is inconsistent with the approach that the Commission has taken, for example, on the Atlanta Report.

THE COMMISSIONER: Well ---

MR. SCOTT: One second point, and perhaps I don't need to argue this, but when Mr. Sopinka asked those questions - I am sorry, when Mr. Percival asked those questions we have no access, and I presume we are going to get it before he cross-examines again, to the statements the police have, made by some of these witnesses, and the report that was made by the police to the Attorney-General.

We don't need that now because we take the position that that is all a Phase 2 matter and we don't need to press you to let us have that until Phase 2. But if he is going to ask questions about it now, we should not be deprived of that information that is within the power of Mr. Marshall



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C2 and Mr. Percival one moment longer because I can't deal with his cross-examination ---

THE COMMISSIONER: I thought Mr. Lamek told me yesterday that all of these statements were handed to the witness.

MR. LAMEK: They were indeed, Mr. Commissioner.

THE COMMISSIONER: I don't see how you can complain ---

MR. LAMEK: They were provided to Dr. Fowler as they were to Dr. Freedom and Dr. Rowe before him.

MR. SCOTT: No, no. What is being provided to Dr. Fowler is a copy of an interview that Dr. Fowler gave to the police.

THE COMMISSIONER: Yes. I am sorry. I thought that is what you were complaining about.

MR. SCOTT: No. I want all the interviews that the police conducted. If this question is going to be significant, why should I be given only Dr. Fowler's?

THE COMMISSIONER: Well, I know, but you can go too far with this.

Mr. Percival, I don't know why I should be doing all this arguing for him because he is a very



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able fellow and he could do it himself, but he could ask you for the notes of interviews --

MR. SCOTT: You do very nicely if I might say so.

THE COMMISSIONER: -- notes of interviews that you have had with all of your clients; I'm not going to ask that they be put in.

MR. SCOTT: No, no. I am not going to ask for notes of interviews with his clients. I am asking for statements that he obtained and the report of the investigation.

THE COMMISSIONER: They have been given. Those affecting your clients with your witnesses have all been given to them.

MR. SCOTT: Each witness who is being called is being provided a copy of an interview he made with the police.

THE COMMISSIONER: That is right.

MR. LAMEK: Let me be clear, Mr. Commissioner: he has been provided with everything that I have concerning any contact he had with the police, be it a note of an interview, a statement, a summary, whatever.

MR. SCOTT: Yes.

MR. LAMEK: I have provided to him.



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3 MR. SCOTT: Yes. I say if you
4 were going to get into these issues we are entitled
5 to have more than that. Because Mr. Percival has it
6 and cross-examines from it - I don't criticize him;
7 I think his cross-examination is fine. But he has it,
8 and if he has it why shouldn't the others have it?

9 MR. COMMISSIONER: All right. Just
10 let me say this all started because Mr. Brown stood
11 up yesterday and he said that, and it was relating
12 to one question, a series of questions that had been
13 asked by Mr. Percival relating to his observation of
14 Susan Nelles on the morning of the 22nd of March.

15 In my view it is unfair if a statement
16 had been given to the police that that should not be
17 made available for cross-examination if it conflicted
18 in any way, or you don't have to cross-examine on it;
19 you don't have to do anything, but my theory on that
20 is it would be unfair to Susan Nelles herself if
21 that weren't - that is as far as any ruling I have
22 made with respect to any statements that anybody has
23 made.

24 Mr. Lamek tells me he has given all
25 the statements that he has to each witness and will
continue presumably to do that.

MR. LAMEK: Yes.



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THE COMMISSIONER: For each witness throughout the hearing.

Now do you want to say something, Mr. Labow?

MR. LABOW: Yes. I am sure Mr. Scott doesn't need my support, Mr. Commissioner, but I would like to make one other point.

THE COMMISSIONER: Yes.

MR. LABOW: We are in a position where Commission Counsel have been asked to provide us with an idea of what the witnesses' evidence will be, and they don't have the time to do it and I don't criticize them for that.

THE COMMISSIONER: Yes.

MR. LABOW: But clearly if they could give us the statements of the witnesses --

THE COMMISSIONER: In all history there has never been a greater opportunity for counsel to know what witnesses are going to say. They have all said it in the Preliminary Inquiry.

I went through my life in the practice of law without any of these benefits and still had to stagger through cross-examination as best I can.

You have all the opportunity to prepare yourself, and not only that, but as I believe the



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2 Preliminary Inquiry has been made available, has it
3 not? Plus all the exhibits of the Preliminary Inquiry?

4 All of this question has been gone into,
5 so I am not really that sympathetic, but in this
6 particular case what has happened apparently was that
7 there was a statement made by this witness to the
8 police relating to this particular incident, and I
9 thought it would be fair if that were presented, not
10 to the world, but to Mr. Sopinka. That is all.

11 MR. LABOW: I understand that.

12 THE COMMISSIONER: Now that is as
13 far as any ruling I have made has gone.

14 This is turning into a great exercise
15 on the course of the Commission. I find it easier
16 because every time I make a general statement I
17 regret it the next day. So I prefer to make rulings
18 as we go along, or as Mr. Scott would put it, to
19 avoid making rulings as we go along.

20 But that ruling, I said I would hear
21 further argument if anybody has any other reason
22 why Mr. Sopinka should not see that particular state-
23 ment.

24 I am told there is such a statement,
25 and I am told that Mr. Lamek or Miss Cronk or somebody
has it, and is there any reason why that can't go



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C7

to Mr. Sopinka?

Do you still want it, incidentally,
Mr. Sopinka?

MR. SOPINKA: Oh, yes, I am grateful
for small mercies.

THE COMMISSIONER: Yes.

MR. SOPINKA: But by accepting it -
I support Mr. Scott --

THE COMMISSIONER: Yes.

MR. SOPINKA: I think an individual
statement made may be completely out of context, when
one looks at the totality of the investigation --

THE COMMISSIONER: Yes, it may well
be.

MR. SOPINKA: If one party has it
why shouldn't another party have it?

THE COMMISSIONER: Well, you can
do what you like with it.

MR. SCOTT: Mr. Commissioner, can
I give you an example of the problem that relates to
this very case? And first of all let me be perfectly
clear that Mr. Lamek when he interviews a witness
at the Hospital hands over every statement or report
of interview or note that Mr. Lamek has in his
possession that that witness made. And I have no



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quarrel about that.

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He has been very fair in his interview-
ing. Examination is something else but the interviews
are wonderful in every respect.

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The problem here is we are now concerned
because it has been raised, I thought out of order,
but that is beside the point, what Susan Nelles
looked like on a certain day. And it is true that
Dr. Fowler has seen a copy of an interview he gave
to the police.

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The problem is that, for example, there
was another person there at the very same time,
Phyllis Trayner, to take an example. We don't have
her statement as to what Susan Nelles looked like at
that time.

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We have what she said in the Preliminary
Inquiry, true, but we don't have her statement.

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Mr. Percival I presume does. And if
we are going to - if anybody is going to cross-examine
Dr. Fowler about his observations about Susan Nelles,
it seems to me only fair and quite routine that you
should be able to say well, did you know that somebody
else was there at the same time and had a different
view?

That would be routine in a court.



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2 That we can't do unless the Attorney-General or
3 Mr. Percival make this kind of disclosure.

4 I didn't ask for the disclosure because
5 I thought these to be Phase 2 matters, but if they
6 are not it seems to me the disclosure should in fair-
7 ness to all the other counsel be made.

8 THE COMMISSIONER: All right. Now,
9 Mr. Percival, I am exhausted.

10 MR. PERCIVAL: I am only going to
11 make very, very brief comments. I don't wish to
12 anticipate motions that are talked in airy-fairy
13 language or stated cases that are threatened towards
14 you, Mr. Commissioner. We will meet them as we come
15 to them.

16 It seems to me that Mr. Young said
17 to you yesterday and I reiterate his comment, cross-
18 examination was solely, simply, with respect to the
19 evidence given under oath on an earlier occasion,
20 preliminary hearing, all of which has been available
21 to every person in this room for many months. It
22 was not on a statement. If, and I am prepared to
23 accept your ruling, Mr. Lamek wishes to, if your
24 Lordship or Mr. Commissioner has directed Mr. Lamek
25 to give Mr. Sopinka that statement, that is your
prerogative. I accept it. Please cross-examine.



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THE COMMISSIONER: Yes. All right.

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Well, I'm not going to call for - yes, Miss Kitley,
4 you have got something?

5

MS. KITLEY: I have one very brief
6 comment on the statement, sir.

7

There are statements and there are
8 statements, and I am concerned if there is an inter-
9 view, for example, that was taken down notes by
10 someone else and it is a summary - we don't know
11 who was there and we don't know who took the notes -
12 those kinds of statements, so called, in my submission
13 ought not to be released. Whereas a signed statement
14 is if that falls within the category of what
15 Mr. Sopinka is after.

14

THE COMMISSIONER: I wouldn't have
15 thought it makes an awful lot of difference whether
16 it was signed or not.

17

MS. KITLEY: Well, in my submission
18 it does. I am thinking not so much of Dr. Fowler
19 as the statements or the interviews or the notes
20 or whatever that were made by our clients.

20

THE COMMISSIONER: Yes.

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MS. KITLEY: And I would not want
22 them to be in a position of having an interview and
23 notes that they were not the author of and did not
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sign and may not even have seen to be distributed to all counsel.

THE COMMISSIONER: Well, this is not my intention of distributing it to all counsel. It was Mr. Sopinka only.

MS. KITELY: Well, I think --

THE COMMISSIONER: And he may not want to have anything to do with it. But because his client is concerned. That is all. No one else is concerned with respect to this.

Everybody has been through cross-examination and nobody raised that issue, and really I am prepared to concede it may well be more relevant to the second issue than it is to the first, but I'm not prepared to say it hasn't some relevance to the first.

MS. KITELY: Whether a statement is produced to one counsel such as Mr. Sopinka or everybody in the room, the point is it is released in advance of the witness taking the witness stand, or in the case of Dr. Fowler while he is on it.

THE COMMISSIONER: Yes.

MS. KITELY: And I would just ask that that distinction be maintained.

THE COMMISSIONER: Yes. All right.



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Thank you.

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Well now is this statement available?

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Is it now?

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Do you want to say something about it

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too?

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MR. LAMEK: No, I'm going to wait

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until the full argument and keep my powder dry until
then.

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There is indeed a statement made by
Dr. Fowler to the police on March 24th, 1981, a
virtually contemporaneous statement with the events
that were in issue yesterday.

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It relates solely, after you have
gotten through the background information about who
he is and what he does, relates solely to the events
concerning the admission, treatment and death of
Justin Cook and the observations that Dr. Fowler made
on his arrival at the Hospital following Justin Cook's
death.

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THE COMMISSIONER: Yes.

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MR. LAMEK: It is a signed statement,
and I say to you, Mr. Commissioner, Miss Kitley is
entirely right. There are very few signed statements
among the information I have obtained from the police.
Many of them are in the form of what I understand



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are called "will say statements". That is documents prepared for the Crown's brief by the police officers, attempting to summarize what they expect a witness will say, which may or may not be an accurate reflection of what the witnesses said to them.

In this case, however, I have a signed statement and I have a typewritten transcript of it attached to it. That I think completely covers the matter that was raised by Mr. Percival yesterday, and that I think is a document in which Mr. Sopinka will be interested.

THE COMMISSIONER: Yes.

MR. LAMEK: And if you so direct, sir, I am prepared obviously to provide him with a copy of that.

THE COMMISSIONER: Well, unless anybody else has anything else to say?

Yes, Mr. Shinehoft?

MR. SHINEHOFT: The only comment I would like to make, Mr. Commissioner, you made a statement that in all likelihood it was Mr. Sopinka that would only be interested in some of these statements, and what I am putting forward is that if we don't know what the statements say --

THE COMMISSIONER: That is right.



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MR. SHINEHOFT: -- and we don't know who they are applicable to in terms of which of the babies, how can we as counsel for the parents say whether we would want the statement or not?

THE COMMISSIONER: No, obviously you can't.

The question did not have anything to do with anything except the condition of Susan Nelles at that particular time. The only person, and I have to - I am not going to open up all the statements; certainly not at this time to everybody - so I am just simply not going to give it to anybody.

I don't know what Mr. Sopinka is going to do with it. He may put the whole thing in to this witness. I have no idea. That it was for that purpose and that purpose only because it was unfair in my view to Susan Nelles that that statement could be made without her counsel being able to see the statement that she may have made to the police.

Now that is all.

MR. SHINEHOFT: I understand that, Mr. Commissioner, but --

THE COMMISSIONER: But I am not providing statements to everybody just so that they can question the witnesses. That is not my idea,



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at any rate at this point of doing. We are dealing
only with this one.

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MR. SHINEHOFT: I am saying if

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that eventuates, Mr. Commissioner, that presumably

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all counsel will be entitled to all statements or

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those counsel with whom the --

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THE COMMISSIONER: I don't think

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that follows. I don't think that follows at all.

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It seemed to me to be unfair in this

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instance. I see no reason why I have to order that

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all statements made by all persons must go to all
counsel.

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Certainly all of the documents upon

14

which the Commission is relying of course, and intends

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to tender in evidence, should be put before you -

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should be given to everybody, but in this instance I

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do not intend it to go any further than Mr. Sopinka.

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MR. SHINEHOFT: I appreciate what

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you are saying, Mr. Commissioner, in this very

instance --

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THE COMMISSIONER: Yes.

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MR. SHINEHOFT: -- but what I want

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to say -

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THE COMMISSIONER: I will have to

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think it out.

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MR. SHINEHOFT: -- I can't say to you I am not interested in a particular statement of a particular witness because I don't know if that statement affects my position unless I see the statement.

THE COMMISSIONER: All right. Okay. Thank you.

Now do you want to give it to Mr. Sopinka?

Do you want to read it, I suppose, before you cross-examine?

MR. SOPINKA: If I could have five minutes.

MR. LAMEK: I was about to suggest the same thing. There is another matter I would like to speak to Mr. Sopinka about, Mr. Commissioner.

THE COMMISSIONER: Well, what time is it now?

MR. LAMEK: Seven minutes to 11:00.

THE COMMISSIONER: And are you due some place else? You can only give us a reasonable amount of your time? Is this a problem, because I would like to continue until half past 11:00 with Mr. Tobias and then you can come on right after that.

MR. SOPINKA: Well if you want to



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continue for another half hour.

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MR. MARSHALL: The newspapers don't

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go to press for three-quarters of an hour.

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MR. SOPINKA: Only the Attorney-

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General would know that.

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If I could just have five minutes to

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look at that statement, and my cross-examination will

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be no more than --

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THE COMMISSIONER: While you are

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looking at that statement can I cannot continue with

12

Mr. Tobias?

13

MR. SOPINKA: Yes, sure.

14

THE COMMISSIONER: Yes. All right.

15

MR. TOBIAS: Mr. Commissioner, if I

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could suggest, perhaps, we could take the morning

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break now.

18

I am not anxious to start and go

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for five minutes and then stop.

20

I broke at the time I did because I

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was planning to get into another area completely.

22

MR. LAMEK: Mr. Commissioner, fairly,

23

I think I need a couple of minutes, not only with

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Mr. Sopinka but Mr. Percival and Mr. Marshall as well.

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THE COMMISSIONER: Yes.

MR. LAMEK: And perhaps we could



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just rise literally for five minutes and then come
back?

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THE COMMISSIONER: Well I think

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we will probably take the break now. It is probably

6

the sensible thing to do. If there is nobody on my

7

side I can't resist it so we will take 20 minutes now

8

and come back at quarter past 11:00. Then you can

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read to your heart's content and then you can proceed.

---Short recess.

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---On resuming.

THE COMMISSIONER: Yes all right, Mr.
Sopinka.

CROSS-EXAMINATION BY MR. SOPINKA:

Q. Dr. Fowler, I represent Susan
Nelles.

A. Yes.

Q. When you attended at the
hospital and observed Susan Nelles as you have
testified.

A. Yes.

Q. How long was that after the
death?

A. It must have been a few minutes
afterwards, because I was notified of the death and
had to drive to the hospital, so that must have
been possibly three-quarters of an hour to an hour.

Q. Three quarters of an hour
after?

A. Of the death. Well, I can't
say, but it would be in that near area.

Q. Were you interested to know
when you were observing Susan Nelles how long that
was after the death?

A. No, I don't know precisely.



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Q. Wouldn't that be material?

A. Yes.

Q. Now, as I understand it when you said she looked strange or unusual, what you meant was out of keeping with your subjective assessment as to how she should look?

A. Yes, I felt that she was ---

Q. Excuse me, is that right or wrong?

A. Yes, that is right.

Q. And it was because she wasn't crying, isn't that so.

A. Yes.

Q. So really what you meant is that she looked different than you expected but you didn't really have anything to base it on?

A. No, because I don't know her personally.

Q. And you really had a glance at her, didn't you, you just glanced at her?

A. Yes.

Q. And she was writing?

A. Yes.

Q. Did you speak to her?

A. No, I didn't speak to her.



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Q. You know nothing of the way she handles grief?

A. No, I have no idea.

Q. And you would agree with me that different people handle grief differently?

A. Very true.

Q. Some cry, some don't?

A. Yes.

Q. And was Dr. Jedeikin crying?

A. No.

Q. Well you wouldn't say, you wouldn't tell the Commissioner that you expected nurses to cry and doctors to remain brave, would you?

A. No.

Q. And did you speak to any other people who had been present at the time that Justin Cook died, to find out what Susan's reaction was then?

A. No.

Q. I will just read to you what Dr. Jedeikin said at the preliminary hearing. He was asked about Susan Nelles at the time that Justin Cook died and Mr. Cooper says ---

THE COMMISSIONER: Yes Mr. Young.



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MR. YOUNG: May we have the citation.

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MR. SOPINKA: Page 29, I am sorry.

4

MR. YOUNG: I just wanted to know what
Mr. Sopinka was reading from.

5

MR. SOPINKA: Volume 22, I am sorry.

6

7

"MR. COOPER: I suggest she
was visibly upset, is that correct?

8

"A. That is correct.

9

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"Q. At one point crying, isn't that
correct?

11

"A. That's correct.

12

"Q. I take it you were a little upset
too, were you not?

13

"A. Absolutely.

14

15

"Q. And as I understand it you tried
to comfort Susan Nelles to some extent?

16

"A. That's correct.

17

18

"Tried to indicate that he had been
given the best nursing care and that
these things happen. Is that correct?

19

"A. That's correct."

20

21

Now assuming that evidence is accurate
then Dr. Jedeikin obviously saw Susan Nelles crying?

22

A. Yes.

23

Q. He tried to reassure her and

24

25



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2 comfort her?

3 A. Yes.

4 Q. He certainly didn't think she
5 looked strange?

6 A. No.

7 Q. Why wouldn't - before you told
8 the police that she looked strange why wouldn't you
9 ask somebody how she looked at the critical time?

10 A. Well that was a very stressful
11 time to me and I was trying to deal with a lot of
12 things going on that were unexpected, and I didn't,
13 I didn't go into that.

14 Q. And did you happen to take
15 the time to read what His Honour Judge Vanak said
16 about that evidence?

17 A. I don't know that I have read
18 that, I am sorry.

19 Q. Well, let me read it to you,
20 this is in the Reasons at page 52:

21 "Several of these items of evidence
22 relate to utterances and conduct
23 following closely after the death of
24 Baby Justin Cook on Sunday March 22nd,
25 at about 5 o'clock a.m.

Dr. Fowler testified that he did not
see Nelles that morning until he was



Fowler, cr.ex.,
(Sopinka)

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2 "about leave the hospital. That as
3 he was leaving he saw Nelles sitting
4 at one of the desks in the nurse's
5 station apparently writing up the
6 final report in Cook's medical chart.
7 He said he knew she had been involved
8 with Pacsai and had given the digoxin
9 before and was anxious to see what she
10 looked like at this time. He glanced
11 in her direction and said she had a
12 strange expression on her face and no
13 sign at all of grief. He thought this
14 was very strange that this would be
15 her appearance at a time such a terrible
16 thing had happened.
17 With respect, while it appears that
18 Dr. Fowler went to school with Nelles'
19 father many years ago and may have had
20 some isolated transactions with her
21 since then, he barely knew Susan Nelles
22 if at all, he knew nothing about her
23 emotional range, or her reaction to
24 stress or her manner of expressing
25 her grief.
I am unable to find any evidence of



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2 "guilt from what a doctor thought from
3 a passing glance as a very strange
4 expression on the face of a very young
5 woman who he barely knew and had
6 suffered a most harrowing experience
7 and was engaged in the very emotional
8 disturbing duty she was bound to perform
9 of writing up the final death note as
10 part of her other difficult duties on
11 the occasion of the death of a baby in
12 her care."

13 Would you agree with that statement
14 by His Honour Judge Vanak?

15 A. Yes.

16 Q. And when you told the police,
17 or made the statement to the police, I suggest to you
18 that you did not intend that as evidence of murder?

19 A. No, I did not.

20 Q. And you did not intend them to
21 act on it, and the day after you gave your statement
22 to lay the charge?

23 A. No.

24 Q. And did the police ask you to
25 explain, because I don't see anything in the police
statement which I now have, and if you haven't read



1
2 it ---

3 A. No, I have read that.

4 Q. They don't appear to have asked
5 you anything about, to explain what you meant to
6 enable you to explain as you have here what you meant
7 by the word "strange"?

8 A. No, they didn't ask me.

9 Q. Nor did they ask you what your
10 familiarity was with her emotional state?

11 A. No.

12 Q. Whether you had ever seen her
13 before when there was a situation that called for
14 grief?

15 A. No.

16 Q. They didn't ask you that?

17 A. No.

18 Q. They didn't ask you how long
19 after the death you actually observed Susan Nelles?

20 A. I don't remember them asking
21 me that.

22 Q. Well it is not in the statement?

23 A. No, it is not in the statement.

24 Q. Do you remember them asking you
25 whether you spoke to others as to how she had behaved
at the very time of death?



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2 A. No, I don't remember them asking
3 me that either and that isn't in the statement either.

4 Q. And were they aware when they
5 were speaking to you that you had spoken to Dr.
6 Jedeikin at the very time you attended at the Hospital
and abserved Susan, were they aware of that?

7 A. I didn't discuss Susan Nelles
8 with Dr. Jedeikin at that time.

9 Q. I appreciate that.

10 A. Yes.

11 Q. But did they know that you had
12 spoken to Dr. Jedeikin on the occasion on which you
13 attended at the Hospital and observed Susan, did they
know you had also talked to Dr. Jedeikin?

14 A. Oh I think they must have
15 realized that because we were discussing the medical
16 aspect of the care of the patient.

17 MR. SOPINKA: Fine, thank you very
18 much.

19 THE COMMISSIONER: Yes, all right.

20 MR.SOPINKA: Thank you Mr. Commissioner,
21 I am most obliged to my learned friend for allowing
me to interrupt.

22 THE COMMISSIONER: All right. Thank
23 you.

24 Mr. Tobias?

25



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2 Before you go Mr. Sopinka I just would
3 like to say that I am concerned about the fairness
4 aspect, I am not yet persuaded on the relevancy of
5 the distinction between the two because I still think
6 it has some relevance but I may be persuaded from
7 time to time that it is. I am concerned with the
8 fairness aspect of bringing up things relating to
9 particular people long before they have a chance to
10 reply to it and we may be able to do something about
that. If that is any comfort to you.

11 MR. SOPINKA: I know that you will
12 deal with it in a responsible manner, I certainly
13 didn't intend to be critical.

14 THE COMMISSIONER: You can be as
15 critical as you like, there is no problem about that.

16 MR. SOPINKA: I realize it is a very
17 difficult job being a Commissioner and I don't make
18 those observations lightly and it is a very serious
matter.

19 THE COMMISSIONER: No, no, but it can
20 be very unfair, and when Mr. Scott was telling me
21 about the Atlanta Report I realized that every time
22 you try to suppress or delay something somebody objects
23 to it. I think where it comes to something directly
affecting your client who has a very considerable

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2 interest as you know in this matter, then we might
3 be able to somehow or other bring it on nearer to the
4 point where you can reply to it, and certainly in
5 any event because I think as I told Mr. Brown when
6 you were not here yesterday, if it does happen, and
7 if it does come out even though your cross-examination
8 has been completed I will always entertain an
9 application for further cross-examination and entertain
10 it favourably.

11 MR. SOPINKA: You have been very helpful
12 in that respect and I appreciate that. I do think
13 perhaps we should take an hour some time next week
14 and discuss it further and see if the matter can be
15 resolved, I have no desire believe me to go to the
16 Divisional Court.

17 THE COMMISSIONER: I don't mind, anybody
18 can go to the Divisional Court if they like, they seem
19 to be kind of busy though and I don't know they would
20 welcome too many applications.

21 MR. SOPINKA: You wouldn't have a nice
22 long holiday.

23 THE COMMISSIONER: No I wouldn't
24 because this Provincial Statute doesn't allow me to
25 have that holiday, it says I am to go ahead with
other matters but not deal with that, so I would have



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2 to go ahead while you are off in the Divisional Court.
3 We may be able to do something on that.

4 MR. SOPINKA: Thank you, sir.

5 THE COMMISSIONER: Okay, all right.

6 Now Mr. Tobias, that is a long interval.

7 MR. TOBIAS: Yes, thank you, Mr.
8 Commissioner.

9 CROSS-EXAMINATION BY MR. TOBIAS (Cont'd):

10 Q. Perhaps, Dr. Fowler, just before
11 I begin we can clear up one thing that occurred before
12 the break. I was discussing with you in an attempt
13 to refine our discussion a little bit the various
14 possibilities that had been considered over the course
15 of events with Jordan Hines, and I referred you to
16 a discussion that I had in cross-examination with Dr.
17 Rowe. For Mr. Scott's benefit that discussion appears
18 in Volume 25 at page 4556 and goes on to page 4559,
19 and generally I am going to summarize rather than
20 read it verbatim.

21 I asked Dr. Rowe:

22 "Q. All right. Now, the preliminary
23 autopsy report itself raises the
24 question of Sudden Infant Death
25 Syndrome. So, that is one theory. Am
I correct?

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"A. Yes.

Q. Another theory was Dr. Rose's theory of the viral infection affecting the heart muscle?

A. Yes.

Q. And the third possibility was some problem with the conducting system. Are there any other theories or explanations for this death that were considered or that you were aware of?..."

Now Dr. Rowe then referred me to the possibility of a suspected cardiac tumour that the referring cardiologist had raised, and agreed with me that the preliminary autopsy report ruled that out.

Then I asked him whether there were any other possibilities other than the cardiac tumour and he referred me to the fact, and I am quoting his answer at page 4557:

"A. I think there was a question as to whether it might have been pneumonia."

And he then goes on as well to agree with me that the preliminary autopsy report ruled out the pneumonia as a possibility.

I then asked him whether there were any other theories that he was aware of that were



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considered and put forward, and he said:

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"A. I think that encompasses the
ones that I understood have been
raised."

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I then asked him the preliminary
autopsy report having ruled out the cardiac tumour
whether or not the preliminary report satisfied Dr.
Rose's theory of viral infection, and we got into a
rather lengthy discussion at that point about exactly
what studies had been done. On page 4559 I asked:

11

"Q. All right. And at that point..."

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And I am referring to the fact that certain microscopic
studies had been done but not the full microscopic
studies into the conducting system:

14

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"And at that point did that rule out
to your knowledge her theory..."

16

Being Dr. Rose's theory:

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"...her theory of a viral infection
affecting the heart muscle?

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A. I am not absolutely sure, but
I think it probably did."

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Now there was then Doctor, some further
discussion regarding the specifics of the microscopic
testing which still had to be done on the conducted
system and whether or not that had been done. But



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2 the final reference in my discussion of the various
3 causes was at page 4573, and I say, and this is at
4 the very bottom of the page, Mr. Commissioner:

5 "Q. So if I recall the discussion
6 that we had before as to the various
7 possibilities that had been raised,
8 at the time that the preliminary
9 autopsy report finally came out what
10 we are left with in fact was a problem
11 with the conducting system as one
12 possibility; and SIDS as another
13 possibility, all the other factors that
14 we have discussed before having been
ruled out, is that fair?

15 A. I think that is correct, yes.

16 Q. And it is your recollection that
17 the very extensive and detailed micro-
18 scopic study that would have to have
19 been done in order to rule out the
20 problem with the conducting system
was never done?

21 A. Yes, I don't have any evidence
22 that it was done."

23 Now the point Dr. Fowler is we
24 obviously have to consider digoxin toxicity otherwise
25



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2 we might not be here this morning. It is clear from
3 that discussion with Dr. Rose that we also had to
4 consider SIDS and the problem in the conducting
5 system.

6 We have also discussed a fourth
7 possibility and that is some other completely unknown
8 factor that we haven't talked about, haven't thought
9 about, and maybe hasn't even been discovered yet.
10 Is that a fair summary of what the various possibilities
are in this case?

11 A . These are the possibilities
12 you are not weighting them in terms of ---

13 Q. No, I am not weighting them.

14 A. All right you are listing them
15 and I would agree with that.

16 Q . And as far as the conducting
17 system goes we are going to have some great degree of
18 difficulty in satisfying ourselves about that, because
19 the very, very extensive microscopic slide study that
20 has to be done in order to test that theory out was
21 never done, and as far as we know it can't be done
today.

22 A. Yes, correct.

23 Q. Now, you were testifying, I
24 believe it was the day before yesterday in questions
25



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2 that Doctor, I'm sorry Mr. Lamek, I suppose now we
3 can state with his medical knowledge we might well
4 call him Dr. Lamek, but he did ask you at Volume
5 32 of the transcript, and I refer Mr. Scott to page
6 6069, whether or not you were satisfied with Dr.
7 Rose's enquiry, or whether the query regarding
8 arrhythmias of Dr. Becker was ever satisfied and
9 you gave an interesting answer, you said:

10 "I have never looked into it to the
11 question in detail but if you tell me
12 that the conduction system was never
13 analysed by the pathologist ..."

14 And then you go on.

15 THE COMMISSIONER: What page is this?

16 MR. TOBIAS: 6069 at Volume 32 of the
17 transcript.

18 THE COMMISSIONER: , Yes, all right.

19 MR. TOBIAS: Q. What I am particularly
20 interested in in asking you, Doctor, is this, you
21 again chose the words and would have a better under-
22 standing than I do as to what they mean. You said:

23 "If you tell me that the conduction
24 system was never analysed by the
25 pathologist..."

Does indicate that until September the 13th, 1983 you



1
2 were not aware of whether or not the analysis of the
3 conduction system was ever done?

4 A. That's correct.

5 Q. Now you recall in your March
6 17th letter to Dr. Dworak you yourself posed the
7 very question that further postmortem examination
8 has to be done?

8 A. Yes.

9 Q. And it is clear from the
10 preliminary autopsy report which you supposedly
11 read I would hope?

12 A. Yes.

13 Q. Before September 13th of 1983?

14 A. Yes.

15 Q. That Dr. Becker's biggest
16 problem was the arrhythmias?

16 A. Yes.

17 Q. So you knew that?

18 A. Yes.

19 Q. And you must have also taken
20 note when you read that report of his comment, that
21 this will have to await further microscopic study?

21 A. Yes.

22 Q. And being a cardiologist you
23 knew what that further microscopic study was, am I
24
25



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correct?

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A. Yes.

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Q. And did it not concern you as time went on and as events unfolded, did it not get your curiosity, were you not concerned at all about finding out whether there was an answer or not on the conduction system of Jordan Hines?

A. Well I have to admit that I didn't have that information and I didn't seek it out.

Q. You did nothing at all before September 13th, 1983 to follow that up?

A. That is correct.

Q. Doctor, I find that somewhat strange. You have agreed with me, and I am not trying to be cagey now, but you have agreed with me that basically the parameters of this particular child's case are SIDS, a problem in the conduction system?

A. Yes.

Q. Digoxin toxicity or some other completely unknown factor?

A. Yes.

Q. And it is obvious that one of the things, one of those four things being the



1
2 conduction study is capable of being studied, there
3 is a procedure. I find that that being an essential
4 question you never followed it up, do you have an
5 explanation for that?

6 A. Because I felt that that was
7 a very unlikely cause for his death and that the
8 other information suggested that his death was due
9 to SIDS. That is the reason that I had not put that
10 in the forefront of my mind, and that is the reason
11 that I didn't pursue it with the pathologist.

12 Q. Do you know if Dr. Rowe agrees
13 with you that it was very unlikely, did you ever
14 discuss that with him?

15 A. Well, yes, I discussed Jordan
16 Hines with Dr. Rowe and I was in the Department on
17 several occasions. My conception of all of those
18 discussions was that he was a case of SIDS and this
19 is why I had not pursued this.

20 Q. Doctor, there was a very long
21 and detailed discussion that I took Dr. Rowe through
22 regarding the amount of effort that goes into one
23 of these conduction studies.

24 A. Yes.

25 Q. And we talked about the study
of numerous slides.



1

2

A. Yes.

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Q. We talked about the time period that it would take being somewhat variable depending on whether someone were working on it full time, or not full time. He indicated to me in his evidence that this was a study that could take months.

8

A. Yes.

9

Q. That is a major commitment, a major undertaking?

10

A. Yes.

11

12

Q. If you thought that the conducting system explanation was highly unlikely ---

13

A. Yes.

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BmB.jc

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Q. Why would you have gone along with Dr. Becker in having that study done? Why would such a massive undertaking have been undertaken to begin with?

A. I didn't suggest that he do it. It has to be done in the Pathology Department, it is his decision to initiate that and it was felt on the basis of the other information that there was an explanation for the death and that it was not indicated to do that. I imagine that was his feeling in the fact that it wasn't done.

Q. But you admit you didn't do anything to discourage him from taking that on?

A. Well, I have never talked to Dr. Becker about this case at all. I simply get the communications from him.

Q. All right, one further question on this point. When you refer in your letter of March 17th having to defer the final diagnosis until the post mortem examination is complete.

A. Yes.

Q. One of the things you contemplated was the very massive conduction study, the slide study?

A. Yes.



E.2

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Q. Is that correct?

3

A. Yes.

4

Q. So that is one of the things
you were waiting for but you never followed up to see
whether that information was forthcoming?

5

6

A. Yes, yes.

7

THE COMMISSIONER: Could I just ask a
question on this, Doctor?

8

9

THE WITNESS: Yes.

10

THE COMMISSIONER: What would the
conduction system, the examination, what would it
disclose?

11

12

THE WITNESS: It might disclose
nothing.

13

14

THE COMMISSIONER: Yes, but what
might it disclose?

15

16

THE WITNESS: It might in fact show
that there was disease ---

17

18

THE COMMISSIONER: In the heart?

19

THE WITNESS: --- in the little
electrical area, this SA node where all the electrical
impulses originate or in the - you have seen diagrams
of the conducting tissue in the heart and it might
have shown that there were some hypoxic things that
happened at birth and that sort of thing. It could
have shown that.

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E.3

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THE COMMISSIONER: Well, would it show some further cause of death besides the Sudden Infant Death Syndrome or digoxin poisoning, that is what I'm getting at?

5

THE WITNESS: Yes.

6

7

THE COMMISSIONER: Or would it merely confirm one or the other of those two?

8

9

THE WITNESS: No, I think that would bring up a second abnormality in the heart.

10

11

THE COMMISSIONER: Yes. Supposing it disclosed nothing at all, if it disclosed nothing at all --

12

13

THE WITNESS: Yes.

14

THE COMMISSIONER: -- would it affect your present view?

15

16

THE WITNESS: No, that would be quite consistent with my assessment of the case at the moment, that this was a case of SIDS.

17

18

THE COMMISSIONER: Yes, all right.

19

MR. TOBIAS: Mr. Commissioner, I would like to pursue that just for a moment.

20

21

THE COMMISSIONER: Yes.

22

MR. TOBIAS: Q. It is my understanding that one of the things the study would have done is perhaps given us some clue as to why the arrhythmias

23

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25



E.4

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2 in Jordan Hines' case, isn't that correct?

3

4 A. Yes. But of course, as we know,
5 that some cases of SIDS have arrhythmias that are
6 due to impulses that come down from the brain and
7 secondary to hypoxia during these apneic spells and,
8 so, this is another ---

7

8 Q. Well, the fact of the matter is
9 that in Dr. Becker's view --

9

A. Yes.

10

11 Q. -- and he hasn't given evidence
12 yet, I haven't had a chance to put this to him
13 directly, but it is clear from reading his report, in
14 Dr. Becker's view he was quite troubled with the
15 presence of arrhythmias?

14

15 A. Well, I don't think there is
16 anything in that report that indicates that he is very
17 troubled about this at all. He said that SIDS was
18 a good diagnosis and the arrhythmia was unusual in
19 that situation but we know that cases of SIDS do have
20 arrhythmias on occasion not due to anything else in
21 the conducting tissue, just due to the pathology of
22 SIDS.

21

22 Q. Well, Doctor, the plain language
23 that Dr. Becker used at page 28 of the medical record
24 is:

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"This pathologic evidence, in conjunction with the clinical history, makes the diagnosis of a missed-SIDS a possibility."

A. Yes.

Q. He used the word "possibility".

A. Yes.

Q. And then he goes on to say in the very next sentence:

"However, this does not explain the arrhythmias and further conclusions will have to await examination of the conducting system."

A. Yes.

Q. So, obviously what he had in mind was studying the conducting system in order to see if that explained the arrhythmias?

A. Yes.

Q. And if it did explain the arrhythmias then he would have been far less comfortable calling it SIDS?

A. But he might well have ended up with two diagnoses.

Q. Well, we know that, Doctor, but what I am saying is ---



E.6

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THE COMMISSIONER: Wait, wait, I'm a
little concerned ---

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MR. SCOTT: With the greatest of
respect. Dr. Becker is going to be called I gather,
everybody else is, and Dr. Becker will tell us what
he meant.

7

THE WITNESS: Exactly.

8

MR. SCOTT: And tell us what he did
and tell us what he concluded. If Mr. Lamek is tired
of calling witnesses by then, to help my friend I
will call him, but it doesn't seem to me that to
pursue this is going to be productive. Dr. Becker
will explain his report.

13

MR. TOBIAS: Well, I can't help but
pursue it when the witness himself tells me that
Dr. Becker wasn't concerned, or particularly concerned
with the question of arrhythmias.

17

MR. SCOTT: Well ---

18

MR. TOBIAS: Let me finish, Mr. Scott.
Particularly concerned with the question of arrhythmias
and felt that SIDS was a good diagnosis.

20

MR. SCOTT: He's told you he has never
spoken to the doctor.

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MR. TOBIAS: That is just somewhat
inconsistent with the record.

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E.7

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THE WITNESS: But that is Dr. Becker's assessment and other people have assessed this whole case differently and you are well aware of the other people's assessments and my assessment goes along with them.

MR. TOBIAS: Q. Doctor, all I am saying is simply this. Assuming that this study had been done.

A. Yes.

Q. You have indicated that if you had found no abnormalities whatsoever.

A. No.

Q. That would have been even more consistent with SIDS?

A. Yes.

Q. Or digoxin toxicity. It would be consistent with that as well, wouldn't it?

A. Well, I think that is another question altogether.

Q. Well, would it or wouldn't it?

A. If they had normal studies of the conducting system?

Q. Yes, if there were no abnormalities in the conducting system?

A. Yes, yes, yes.



E.8

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Q. That certainly doesn't rule

3

out digoxin?

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A. Yes.

5

Q. Does it?

6

A. Yes. Well, we could just rule
out an organic abnormality in the conducting system.

7

Q. Exactly, exactly.

8

A. And it wasn't done and you will
have to get Dr. Bcker's explanation for that.

10

Q. Yes.

11

A. And I think you should ask him.

12

Q. All right. But the fact of the
matter is that the real point of doing the study was
to further examine the question of the arrhythmia and
see if there was an organic cause?

13

14

15

A. Yes.

16

Q. Correct?

17

A. Yes.

18

Q. Right. Now, also in questioning
by Mr. Lamek, and I am referring again to page 6096,
Volume 32.

19

20

THE COMMISSIONER: I think that is
the one we have just dealt with, 6096.

21

22

MR. TOBIAS: Yes, I am dealing now
with the second part of the question, Mr. Commissioner.

23

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E.9

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THE COMMISSIONER: Oh, all right.

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MR. TOBIAS: Q. You were asked:

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"Q. May I ask you this. Do you know whether the query raised by Dr. Becker's autopsy report as to the explanation for the arrhythmias was ever satisfactorily answered?"

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And then you gave your answer that I have just referred to:

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"A. Well, I haven't looked into this in detail, but if you tell me that the conduction system was never analyzed by the pathologists, in which they may take many, many sections of it all the way down on and look at it, then we can say that we haven't been able to prove something wrong with the conduction system."

19

And then you go on to say:

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"Certainly this electrocardiogram is somewhat abnormal in which you are switching from a rapid to a slow heart rate, and this is consistent I think perhaps with something like SIDS but I am not sure, because this



E.10

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"is, as you know, this is an unusual accompaniment of Sudden Infant Death. I think Dr. Rowe, one of the things that is often suggested as one of the ECG findings of missed-SIDS, is a long QT interval. It was thought that maybe this was the reason for some of these babies dying, and this child doesn't seem to have that certainly on this electrocardiogram that we are seeing now on page 12."

Now, Doctor, with respect to the shifting from a rapid to a slow heart rate, tachy/bradycardia, is that a consistent and a commonly recognized symptom of digoxin toxicity as well?

A. That can be seen in digoxin toxicity.

Q. All right. I take it that is because the drug affects the heart's performance in its beating?

A. In the conduction system.

Q. All right. Now, we know, do we not, that the phenomenon of seeing an arrhythmia in the case of SIDS is a fairly rare occurrence?

A. Yes.



E.11

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Q. I won't put it that way. What I will say is that the literature reports only a very small, small number of cases where that has been verified.

6

A. Yes.

7

Q. Is that correct?

8

A. Yes, yes.

9

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Q. We also know, and I'm relying here on what you said about Dr. Rowe's opinion and your own information, we know that one of the specific things that we see on an ECG recording is often a very long or a somewhat long QT interval?

13

A. Yes.

14

15

Q. Which then in fact can be the cause of ventricular fibrillation, is that not correct?

16

A. Yes, yes, that's true.

17

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19

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Q. And part of the problem, correct me if I'm wrong, with our state of knowledge regarding the connection between arrhythmias and SIDS is the fact that very often and in most cases the SIDS episode happens not in the hospital but at home?

21

A. Yes.

22

23

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Q. Where there are no monitoring capabilities and it is not very often that we are able to have tracings, ECG tracings in the case of SIDS?



E.12

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A. Yes.

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Q. So, for all of those reasons,

4

the question of arrhythmias and their role in SIDS is
very, very cloudy. Would you agree with that?

5

A. Yes, that's true.

6

Q. All right. But it can be that

7

tachy/bradycardia is seen more often in cases of
digoxin toxicity. Is that fair?

8

9

A. Now, when you are making this

10

suggestion, this infant had digoxin - not digoxin

11

but had tachy/bradycardia during his - for some time

12

before his admission to our Hospital. This was the

13

history that we received from the other hospital and

14

the mother noted that the child had a slow heart rate
during the time of the spell that she saw.

15

Q. Yes.

16

A. Yes.

17

Q. All right. I recognize that.

18

All I am asking you is this. Would you agree with me,

19

if you had to rank them, that the phenomenon of tachy/

20

bradycardia is probably more common and more consistent
with digoxin toxicity than with SIDS?

21

A. But in this particular case.

22

Q. I am not asking you about this

23

particular case right now.

24

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E.13

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MR. SCOTT: Well, Mr. Commissioner.

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THE WITNESS: No, but that is what

4

we are talking about.

5

MR. SCOTT: He's not talking about that.

6

MR. TOBIAS: I phrased my question

7

very specifically. Is that a fair conclusion on the
basis of the literature?

8

THE COMMISSIONER: Yes, yes. Now,

9

just to solve this problem so you understand, Dr.

10

Fowler. Answer the question and then go on to say

11

whatever you like. You can do it any way. You can

12

say what you want to say and then as long as somewhere

13

along the line you answer the question, that's all.

14

THE WITNESS: Yes.

15

THE COMMISSIONER: But don't forget

16

to do it. I think the answer to the question probably
is yes.

17

THE WITNESS: Yes.

18

THE COMMISSIONER: But - and then do

19

you want to go on with the but?

20

MR. TOBIAS: I'm sorry, Doctor?

21

THE COMMISSIONER: The answer was "yes".

22

THE WITNESS: The answer is yes and

I won't qualify that.

23

MR. TOBIAS: Q. Yes, all right. Now,

24

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E.14

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in fairness to you, you did say there was evidence
beforehand in the case of Jordan Hines of this
phenomenon. However, am I not correct that Jordan
Hines was only in North York General Hospital for
less than 24 hours?

6

A. Yes.

7

8

Q. Before he was transferred down
to Sick Kids?

9

A. Yes.

10

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Q. And we certainly don't know
what his heart rate was at home because the mother
is not trained and there is no way that she could
have monitored it?

13

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A. But she mentioned I think in
her history that the heart rate was slow. I'm not
positive and if you have gone over the history and
found that she didn't say that, that's all right. But
at least for 24 hours he had the rapid and slow heart
rate.

19

20

21

Q. All right. And in fairness to
you it is also true that he was in the Hospital for
Sick Kids for somewhat more than two days?

22

A. Yes.

23

24

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Q. I think it was about 50 some
odd hours?



E.15

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A. Yes.

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Q. So, we would have had a heart
rate there?

4

5

A. Yes.

6

Q. Okay. Now, one of the things

7

that Dr. Rowe suggested in his evidence, and you

8

mentioned it again at Volume 32 when you were

9

discussing this question with Mr. Lamek, was that

10

often if you do have an ECG tracing in a SIDS or in

11

a missed SIDS case, that we tend to see the prolonged

12

QT interval and you yourself mentioned that, looking

13

at the medical record of Jordan Hines, specifically

page 12, you didn't see that in his medical record.

14

Now, is there any other indication

15

anywhere else in his record that you are aware of

16

where there was a prolonged QT interval recorded?

17

A. No.

18

Q. All right. Now, in both

19

Dr. Becker's autopsy report and in Dr. Rowe's

evidence, they both raise the question of the episode

20

at home having perhaps been missed-SIDS?

21

A. Yes.

22

Q. And that was one of the things

23

that led Dr. Rowe to believe that the final episode

on March 8th, 1981, was indeed SIDS?

24

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E.16

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A. Yes.

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Q. Now, doesn't the lack of any evidence beforehand of a prolonged QT interval bother you?

5

6

A. No, because ---

7

Q. In terms of sharing that view of SIDS?

8

A. No.

9

Q. All right, tell me why not?

10

11

A. Because it has now been found that the majority of missed-SIDS, people that were thought to have SIDS and then actually survived, and you can do ECG's, that it is only a small percentage of those people who actually have a long QT interval, as I understand, and now this is not my field but I understand that that is not thought now to be nearly as important as it was at one time before.

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Q. Well, isn't it also true in that the other percentage of SIDS cases that are studied where there is no QT interval shown, that there is also no other evidence of any kind of any arrhythmias shown? Isn't that correct?

22

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A. No, I can't make that statement because I haven't read all these papers and seen all the electrocardiograms.



E.17

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Q. Well, perhaps we can come back
to that in a few minutes.

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You were asked by Mr. Lamek in your
direct examination whether or not it was true that
the literature suggested that in those cases where
they do have an ECG tracing, in cases of SIDS, the
arrhythmia seen is a prolonged QT interval and your
answer ---

9

10

11

A. Well, that isn't, if I could
interrupt, a long QT interval is not an arrhythmia,
that is characteristic of the electrocardiogram itself.

12

13

14

Q. Right, I recognize that and if
I understood your evidence it was the prolonged QT
interval which causes ventricular fibrillation?

15

16

A. That's right.

17

18

19

Q. It is the ventricular fibrillation
in fact that is the arrhythmia?

20

21

A. That is the arrhythmia, yes.

22

23

24

25

Q. Am I not correct?

A. Yes.

Q. All right. Now, your answer
to Mr. Lamek's question regarding the prolongation of
the QT interval was:

"A. That is a potential, that is the
abnormality at rest. But then when



E.18

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"they get the arrhythmia it might well be a ventricular fibrillation type of thing is a terminal event and that is started by the long QT interval."

Now, my concern is this. Mr. Scott in his re-examination of Dr. Rowe made, I think, a quite valid point. In most cases of heart failure of cardiac arrest the final event is either the stopping of the pumping action or the fact that it is just not pumping sufficiently to circulate the blood to other parts of the body and the body dies?

A. Yes.

Q. Is that a fair statement, do you agree with that?

A. Yes, that is one mode, electrical mode of death.

Q. All right. Now, when we talk about cardiac arrest, either complete stopping of the pumping chamber or its lack of efficiency in pumping, isn't usually the last characteristic event in the chain of events ventricular fibrillation?

A. That is often the end but sometimes it just stops completely, it asystolated.

Q. Fine. Now, if it stops entirely



E.19

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then by definition you don't have ventricular
fibrillation?

3

4

A. That's right.

5

Q. You've got nothing, it stopped
completely?

6

7

A. That's cardiac arrest.

8

9

Q. All right. But if you keep
getting electrical activity on the cardiogram but
the body is dying because that activity is not
characteristic of an efficient pumping action then
that is ventricular fibrillation?

10

11

12

A. That's correct.

13

Q. And that's the final event
which causes death?

14

15

A. In those patients that die in
ventricular fibrillation.

16

Q. Exactly.

17

A. All right.

18

19

Q. Exactly, I am ruling out the
ones who don't die in ventricular fibrillation but
die because the heart stops completely.

20

21

A. Asystole, right.

22

23

Q. All right. Now, the fact of the
matter is it is the prolonged QT interval in those
rare cases which is triggering the ventricular
fibrillation?

24

25



E.20

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A. Yes.

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Q. All right.

4

THE COMMISSIONER: I am sorry, in which rare cases?

5

6

MR. TOBIAS: The rare cases where there is arrhythmias seen accompanying SIDS.

7

THE COMMISSIONER: Yes, oh, I see.

8

9

MR. TOBIAS: Q. Okay. So, my point is this, Doctor. It is not the ventricular fibrillation that causes the SIDS in that particular theory, in fact, the ventricular fibrillation is the result of the prolonged QT interval and that is the cause of the death. Would you agree with that?

13

A. In that type of case.

14

Q. Right.

15

A. It has a long QT.

16

Q. Right, in that particular type.

17

So that, No. 1, since there was no evidence anywhere of a prolonged QT interval seen in Hines and there was no evidence of that being the cause of ventricular fibrillation in his case and, secondly, because ventricular fibrillation is merely the last chain in the event, the fact that the arrhythmia was there, doesn't necessarily point to SIDS as a cause. Would you agree with that?

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E.21

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A. Which arrhythmia, you mean for ---

3

Q. The arrhythmia that Hines

4

suffered in his particular case?

5

A. I don't understand your question.

6

Q. All right. Well, let me see

7

if I can rephrase that. We know that there was no
evidence of any prolonged QT interval.

8

A. Correct.

9

Q. That we know of in Hines?

10

A. Right.

11

Q. So, we have no reason to suspect

12

that that event triggered ventricular fibrillation?

13

A. Yes.

14

Q. All right. So, that mode of

explanation becomes pretty tentative?

15

A. Yes.

16

Q. All right. Now, you say that,

17

well, you know, in some of these cases of SIDS you

18

see ventricular fibrillation, but you have just

19

agreed with me, I thought, that that was not the

20

cause of the SIDS death, it is the QT interval which

21

triggers the ventricular fibrillation?

22

A. Yes, but of course there are

23

many other things and they are all listed for you here

24

that can make you go into ventricular fibrillation.

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Doctor, but --

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MR. SCOTT: Just let him finish,

5

please.

6

MR. TOBIAS: Q. Okay, finish, please.

7

You were saying there were also of other things that
can make you go into ventricular fibrillation.

8

A. Yes. That is right.

9

10

Q. All I am saying, Doctor, is
this: if we see ventricular fibrillation in the case
of Jordan Hines, that is not necessarily indicative
of SIDS because we don't see the prolonged QT interval
that triggers it. Do you agree with that?

13

14

A. Yes, but I don't understand
what your argument is.

15

16

We are not trying to say that because
you have ventricular fibrillation with a normal QT
that he doesn't have SIDS. That isn't logical.

17

18

Q. All right.

19

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A. He could die in ventricular
fibrillation and have SIDS and die because of
hypoxia because he wasn't breathing.

21

22

Q. All right. And I understand
that, and it would be the hypoxia that triggers the
ventricular fibrillation.

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A. Yes.

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Q. All right. So that the only point I am trying to clearly make is the presence of ventricular fibrillation doesn't tell us anything about whether or not it was SIDS?

7

A. That is correct.

8

Q. Okay, fine.

9

10

Now do you or do you not agree with me that SIDS itself is a disease, an illness, without specific autopsy characteristics.

11

12

13

14

A. I have mentioned many times that I am not expert on SIDS because I am in cardiology and I have no special interest in this, and I can't make an authoritative statement.

15

16

Q. All right. Subject to that qualification, and I accept the qualification --

17

THE COMMISSIONER: It is a pretty strong qualification, mind you.

18

19

20

MR. TOBIAS: Well, to your knowledge, Doctor, is it a disease or is it not a disease without specific autopsy characteristics?

21

22

For what it is worth, Mr. Commissioner, I would like it in.

23

THE COMMISSIONER: Well, I --

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MR. TOBIAS: I realize there may be

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a real problem with the probative value, given that qualification, but I would still like to ask the question.

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THE COMMISSIONER: Yes, bearing in mind that there will be a great of problem of probative value, do you think it is worth pursuing?

8

9

MR. TOBIAS: Well, I am only going to pursue it to a simple yes or no. I am not going to delve into it any greater than that.

10

11

12

THE WITNESS: The trouble is if I say no, I will have to spend another few minutes to explain my answer which is --

13

14

MR. TOBIAS: I promise, Doctor, I undertake I won't ask you to tell me why.

15

16

THE COMMISSIONER: I don't want you to say yes just because no would be difficult.

17

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THE WITNESS: I think - the answer to the question is no, and the reason is because there is now information outlined in this particular case as in many other cases that there are abnormalities in pathology of patients who died with SIDS that is becoming related to the diagnosis of SIDS.

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MR. TOBIAS: Q. All right. Fine. One of the things that we have been concerned about in dealing with Jordan Hines because of its relationship



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with SIDS are these periods of apnea?

3

A. Yes.

4

Q. First of all, I might ask you

5

is apnea commonly seen as a consequence of pneumonia

6

or respiratory problems?

7

A. With small babies it can occur,

8

yes.

9

Q. All right. And of course in

10

the Hines case we are dealing with a small baby.

11

A. Yes.

12

Q. Now to your knowledge is

apnea also a common consequence of digoxin toxicity?

13

A. Not particularly.

14

Q. Okay. Now bradycardia is?

15

A. Yes.

16

Q. And is it --

17

A. But if the bradycardia is

the result of apnea, then that goes along with that.

18

Q. Well, I realize that, and in

19

effect we are into a circular problem, but let me

20

just postulate this: it is also possible that apnea

21

can be a result of the bradycardia. Is that not

22

correct?

23

A. Yes.

24

Q. So that you might have

25



1
2 bradycardia induced by digoxin toxicity which would
3 lead to apnea?

4 A. Yes, but it also could have
5 been produced by abnormal sympathetic and para-
6 sympathetic tone coming down to the heart because
7 the child has abnormalities in the brain characteris-
8 tic of SIDS.

9 Q. All right. And another
10 possibility in fact that Dr. Rowe pointed out was
11 some sort of defects in respiratory sytem itself?

12 A. Yes.

13 Q. But my point is this: I want
14 you to help me with the mechanics if you can.

15 Assuming that you have got digoxin
16 toxicity, that can affect the heart rate by slowing it.

17 A. Yes.

18 Q. And that is when you get
19 bradycardia.

20 Now when you slow it down and one
21 of the effects that that is going to have is that
22 the lungs are going to work less efficiently in
23 getting oxygen?

24 A. Yes.

25 Q. And the muscles which control
the breathing rhythm of the lungs are going to be



F6

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affected.

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A. Yes.

4

Q. Because of lack of oxygen.

5

A. Yes.

6

Q. So the mechanics can be, and

7

I realize all the qualifications you have given, but

8

the mechanics can be that in fact in an indirect

9

way the apnea is brought on by digoxin toxicity as

10

a result of the fact that digoxin toxicity induces
bradycardia.

11

A. Yes.

12

Q. Do you agree with that?

13

A. Yes, but studies of digoxin

14

toxicity do not point out apnea as a big common

15

complement or clinical sign.

16

Q. Do you know if Dr. Rowe agrees

17

with your view that in an indirect way apnea can be

18

caused by digoxin toxicity because of it inducing

19

bradycardia?

20

A. I can't remember his evidence

on that.

21

Q. All right. Well let me read

22

you this question and answer. It appears,

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Mr. Commissioner, at Volume 25, page 4591 of the

24

daily transcript:

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"Q. Now, you do agree, and I believe Mr. Percival covered this in his cross-examination, that the apnea and bradycardia, both of those are symptoms that are somewhat consistent with digoxin toxicity?

A. Well, bradycardia is an apnea may.

Q. Apnea might be as a result of the bradycardia; is that not correct?

A. Yes."

Now do you agree with Dr. Rowe's

view?

A. Well, I guess that is true, yes.

Q. All right. Fine. Now are you at all familiar, Doctor, with any of the recent work of Dr. D. Southall who is a cardiologist at Brompton Hospital in London?

A. No, I am not familiar with that.

Q. Okay. Are you at all familiar with the results of a recent study done by a committee headed by the doctor which was published in the British Medical Journal on the 2nd of April, 1983?



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A. I don't think I have read
that.

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Q. All right. It was an article,
to assist you, dealing with the identification of
infants destined to die unexpectedly during infancy,
and a specific evaluation of the predictive importance
of prolonged apnea and disorders of cardiac rhythm
or conduction.

10

Does that ring a bell?

11

A. No.

12

Q. Perhaps I might show you a
copy of the article.

13

THE COMMISSIONER: Well, he says he
hasn't seen it or read it, and it is not his field.

14

15

Now all of this may well be helpful,
and will be helpful to us, but would it not be
better when we have someone who is more familiar with
this to --

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17

18

MR. TOBIAS: Well, given the fact
the witness has already given certain evidence,
subject to qualification I agree, but specifically
with regard to apnea and bradycardia.

19

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THE COMMISSIONER: The only thing,
Mr. Tobias, I don't think it would be helpful to
cross examine him greatly on an article he has never

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read by an author he has never heard of.

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MR. TOBIAS: I just want to put some prepositions to him and find out whether he agrees with them or not.

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THE COMMISSIONER: Well, I guess I can't stop you. I tried or I may, but I don't really think it is going to be helpful, to me at any rate, what he says, whether he says one thing or not. I would be far more interested in --

10

11

12

MR. TOBIAS: The other thing, sir, at least I can produce it today and put it in as an exhibit.

13

14

THE COMMISSIONER: Well, I see nothing wrong with that.

15

16

MR. TOBIAS: We may well wish to refer to it at a later date.

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THE COMMISSIONER: All right. What number are we at?

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THE REGISTRAR: 180.

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THE COMMISSIONER: 180? You have a file cover, but there are three documents. Should they perhaps be 180A, B, and C?

MR. TOBIAS: No. As a matter of fact they should be separate exhibits. I am only referring now to the article that appeared in the



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F10 April, 1983 --

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THE COMMISSIONER: Are you putting
the other two in?

5

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MR. TOBIAS: Yes, I will be putting
the other two in in a few minutes.

7

8

THE COMMISSIONER: Then we will make
them 180. The medical journal, was that the one
that we are talking about?

9

10

MR. TOBIAS: Yes.

11

12

THE COMMISSIONER: Medical Journal
then, Cardiopulmonary Journal, is that the next one
you are going to refer to?

13

14

MR. TOBIAS: I will be referring to
the Cardiopulmonary Journal, April, 1983.

15

THE COMMISSIONER: 181.

16

MR. TOBIAS: Yes.

17

THE COMMISSIONER: And the Australian
Medical Association Medical Journal?

18

19

MR. TOBIAS: That will be the next
one I will be referring to.

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THE COMMISSIONER: 182.

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---EXHIBIT NO. 180: Excerpt from Medical
Journal, April 2, 1982.

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---EXHIBIT NO. 181: Excerpt from Cardiopulmonary
Journal.

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---EXHIBIT NO. 182: Excerpt from Journal of
Australian Medical Association.

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MR. TOBIAS: Q. It would appear --

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THE COMMISSIONER: I just want to

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appeal to you again, Mr. Tobias: these are articles,
I take it, which have something to do with SIDS; is
that right?

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11

MR. TOBIAS: Yes, they are.

12

THE COMMISSIONER: He is not an

13

expert on SIDS.

14

MR. TOBIAS: Yes, I realize that.

15

THE COMMISSIONER: Is he going to

16

be a real help to us? He hasn't read the articles
or had a chance to study them. It is not his field.
Is it really going to help us that much?

17

18

MR. TOBIAS: Only in this sense,

19

Mr. Commissioner, and I am aware of the problem, and
I am not at all concerned about it because I will
have an opportunity with later witnesses --

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THE COMMISSIONER: That is right.

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MR. TOBIAS: To go into it in a lot
more detail.

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THE COMMISSIONER: That is why I

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would much rather --

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MR. TOBIAS: And I recognize that,

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but if we could spend a few moments on it because

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what I would like to do is simply put to the Doctor

7

general propositions. Only general propositions

8

because I want to put to him some logical conclusions

9

that I as a layman am drawing from these articles

10

just to find out if I am completely off base^{or}/if there
is some merit in them.

11

THE COMMISSIONER: Well, all right.

12

Let's try and see what happens.

13

MR. TOBIAS: Perhaps we can try it

14

for a few moments in passing and see what happens.

15

THE COMMISSIONER: All right.

16

MR. TOBIAS: Q. Doctor, the first

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article that I referred to appeared in the April 1983

18

edition of the Medical Journal, and it was the results

19

of a study done in England, trying to determine the

20

predictive importance of prolonged apnea and

21

disorders of cardiac rhythm in predicting cases of
SIDS.

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That really was the entire aim of

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the study, and I understand and I am referring now,

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Doctor, to the abstract:

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"Twenty-four hour taperecordings of electrocardiogram and breathing movement were made prospectively in 6,914 full term and 2,337 preterm infants or infants of low birth weight during the first six weeks of life. These recordings included 40 obtained in 29 infants who subsequently suffered the Sudden Infant Death Syndrome and 13 obtained in 10 other infants who died suddenly and unexpectedly.

None of the recordings obtained in the infants who suffered the Sudden Infant Death Syndrome showed prolonged apnea (cessation of breathing movement for 20 seconds or more) or pre-excitation. One infant had multiple ventricular premature beats (38/hour). Compared with recordings obtained in 211 control infants who did not die none of the recordings obtained in the infants who suffered the syndrome showed abnormal prolongation of the QT interval."

Now it is obvious, or it is obvious to me - I have had the benefit of reading the article -



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that what was done here was an attempt to identify a specific and very large sample of infants and to monitor their breathing and their heart beat and to follow them up later on in life to see if they could determine out of that sample how many children subsequently died. And then to take that group of children who turned out to die and determine from that group how many they were satisfied had succumbed to Sudden Infant Death Syndrome.

And having done that, to then look back at the recordings made earlier in life and the monitoring of their breathing habits and their heart beat to see if they detected any abnormalities in these babies earlier which ultimately showed to be abnormalities seen in babies who died in SIDS.

Do you follow that?

A. I can't really make any comment on this at all. I haven't read the paper. I have no personal experience with this and I can't make any comment at all about this without reading the whole paper and assessing it and then my results or the results of my comments are not very meaningful anyway because I am not a general pediatrician and I am not involved in this. And I think it is meaningless for me to be asked to give a comment in this



1
2 situation in this forum.

3 Q. Well, Doctor, all I am asking
4 you at this point - you may be anticipating questions
5 that I may or may not ask you later - but all I am
6 asking you at this point is to comment on the
7 methodology. If the aim of the study is to find -
8 do you agree with this: you don't know until after
9 the event whether a child died from SIDS or not?

10 A. No.

11 Q. When a child is born there
12 is no way of telling --

13 A. No, I realize perfectly what
14 is going on and what the design of the study is and
15 I can't make a comment on it until I read the whole
16 paper. And I am not involved in reading papers on
17 SIDS. I have enough time trying to read papers on
18 cardiology.

19 Q. Doctor, all I am asking at
20 this point I repeat is whether or not that methodology
21 seems reasonable to you?

22 A. It seems reasonable by looking
23 at the abstract, and I wouldn't even - I don't want
24 to make a comment on that without reading the whole
25 paper and also reading all the literature in SIDS.

I think that you will have to direct



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this type of questioning to somebody who is an expert, who has read the papers and has had physical sort of, or a practice in the fields where he is interested in SIDS, and I think that this is very unfair to present me with a paper that I haven't read because it is out of my field and then to ask me to make some comments on it --

Q. All right.

A. Of any sort.

Q. All right. Fair enough.

At this point all you are really able to tell me, and you have qualified that, subject to the fact you haven't read the paper or looked at the literature, does the methodology seem reasonable enough?

A. I can't even assess that because I want to see the details of exactly what was done and you just can't do that without spending some time.

Q. All right. Let's move on to the next article, Doctor.

A. Well, that will have the same - if it is on SIDS I will have exactly the same sort of result of this as well.

Q. Well, Doctor, I realize that.



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If you will just indulge me for a moment I could assure you that the article I am about to go to is not in fact on SIDS. It has nothing to do with SIDS.

A. All right.

Q. And the article I am referring you to, Doctor --

MR. SCOTT: Before you go to it, the last page of the article there is a short paragraph that is worth reading that shows there will always be an England. It is headed "100 Years Ago", and I commend it to all counsel at lunch.

THE COMMISSIONER: I am sorry, I can't --

MR. TOBIAS: Perhaps Mr. Scott would identify it --

MR. SCOTT: The last page of the Medical Journal that has just been referred to.

THE COMMISSIONER: Oh, the Medical Journal?

MR. SCOTT: There is an article called "100 Years Ago", and that shows there will always be an England.

I am sorry to interrupt my friend.

MR. TOBIAS: That is quite all right, Mr. Scott. I hope that I haven't put in issue whether or not the monarchy will survive. That



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certainly wasn't my intention.

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MR. SCOTT: But I found that

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interesting.

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THE COMMISSIONER: Oh, yes.

6

MR. TOBIAS: Q. Doctor, the next

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article I am referring you to in the Cardiopulmonary
Journal in April of 1983 --

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A. That is the Journal that is

9

called CHEST.

10

Q. All right. Thank you. And

11

it is an article by Drs. Chowdhry, Hariman, Gomes

12

and Nabil El-Sherif entitled "Transient Digitoxic

13

Double Tachycardia".

14

Have you seen that article or are

15

you familiar with it?

16

A. No, I have not read that.

17

Q. It is my understanding that

18

this was an attempt to make ECG tracings of a patient
being treated with digoxin to monitor changes in

19

heart rhythm, and it is my understanding that the

20

methodology in fact that was employed was while the

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patient was being given certain dosages of digoxin

22

by IV and after his clinical history had been recorded

23

very carefully, certain tracings were made in order

24

to follow the heart rhythm and the heart rate to

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see if the digoxin had any effect on heart rate.

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Now given that fact is that fair methodology, do you think?

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A. Well, I think the basic problem in this particular paper that shouldn't be related to our discussions at all is the patient is a 62-year old man.

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Q. Yes, that is correct. That is correct.

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A. And the electro-physiological parameters in people that are 62 years old are very, very different than they are in people who are three weeks old.

Q. All right. Well, I think in fairness let me point this out to you: the point of the article - I have had the opportunity of reading it and of course the article itself will be the true test - but the point of the article seems to be simply this: that digoxin toxicity is expected to result in arrhythmia; that as digoxin is administered and as it is administered in gradually increased doses, it has an effect on heart rhythm and often results in arrhythmia in a 62-year old man.

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A. Yes, and also in children too.

Q. This is --

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A. This is motherhood, you know,
digoxin causes changes in the heart rhythm.

Q. All right. That was exactly
my question. You would have no problem with that
proposition at all?

A. No, I would agree with that.

Q. Now, are you familiar either
with the article that Mr. Scott introduced into
evidence - I believe it was Exhibit 163 - that was
the Valdés-Dapena article. Are you familiar with her
writings?

A. Which article is this?

Q. The Valdés-Dapena article.

A. What is it about?

MR. TOBIAS: Sorry, Mr. Registrar,
it was Exhibit 162. My mistake.

Q. Yes. It is Marie A. Valdés-
Dapena M.D. who wrote on Sudden Infant Death Syndrome
a review of the medical literature in 1974 to 1979.



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A. No, I have not read that.

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Q. You are not familiar with its

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contents, nor with its conclusions?

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A. No.

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Q. I suspect therefore you really

can't help me much with it?

7

A. No.

8

Q. Can you?

9

A. No, I am sorry.

10

Q. Now we talked before, Doctor,

11

about the apnea theory.

12

A. Yes.

13

Q. And I think it is fair to say

14

that that theory is accepted as a working hypothesis

15

by certain of your colleagues who are more skilled

16

and more knowledgeable with SIDS, would you agree with
that?

17

A. Yes, I understand that is one of

18

the explanations for this disorder.

19

Q. Will you simply advise me of

20

this, and again I realize it is subject to all the

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qualifications you have given me this morning and they
are considerable. On the basis of the state of your

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knowledge of the literature, do you feel that despite

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the fact that it is a working hypothesis of some

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number of your colleagues, that in most SIDS infants actual proof of that hypothesis is still lacking and further investigation is required, would you agree with that?

A. No, I can't make a statement on that, I haven't read the literature. I was looking over a recent paper last night and in 1982, and it had 180 references and I don't begin to make any comments at all on SIDS.

Q. You can't tell us, you can't at all tell me that you agree with the statement, is the converse true as well that you can't challenge the statement?

A. What is the statement?

Q. Well the statement was that despite the fact that it is accepted as a working hypothesis by some of the people studying in the field, that in most SIDS deaths proof of the hypothesis is still lacking?

A. Yes.

Q. You can neither confirm that nor deny it, is that right?

A. No, because I haven't read the literature.

THE COMMISSIONER: Is the death itself,



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is the SIDS, is that what the hypothesis is?

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MR. TOBIAS: No, what the hypothesis is briefly, Mr. Commissioner, is that due to some defect in the respiratory system it produces apnea.

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MR. SCOTT: Where is this statement made, I don't find it in any of these papers?

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MR. TOBIAS: Well the statement is made in fact in the third article that I put to the witness which appears in the Journal of the American Medical Association.

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THE COMMISSIONER: Do you mind giving us what the statement is?

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MR. TOBIAS: Yes, I will, sir, I will read it into the record.

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"January 23, 1982 ..."
That was the date of publication, it was a clinical review.

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THE COMMISSIONER: The apnea theory?

MR. TOBIAS: Yes.

THE COMMISSIONER: I see that.

MR. TOBIAS: It says:

"Sudden Infant Death Syndrome and suspected near miss in overview for clinicians by Read, Jeffery, Rahilly."

THE COMMISSIONER: No.



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MR. TOBIAS: I am referring to page 2
of the article, five paragraphs down which says as
follows.

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THE COMMISSIONER: The apnea theory,
is that right?

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MR. TOBIAS: It starts with the words
"The apnea theory ...".

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THE COMMISSIONER: Yes, I have got it.
Thank you.

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MR. TOBIAS: "The apnea theory is
accepted as a working hypothesis --"

12

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THE COMMISSIONER: Can you not state
the theory for us?

14

MR. TOBIAS: All right, yes sir.

15

THE COMMISSIONER: Will you read the
theory so we will understand?

16

MR. TOBIAS: All right:

17

"The apnea theory is a that due to ..."
and Dr. Rowe incidentally discussed this with us.

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THE COMMISSIONER: You just tell me
what it is.

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MR. TOBIAS: "... due to some defect
in the respiratory system which is
peculiar to infants who succumb to
SIDS."

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THE COMMISSIONER: Due to a --

MR. TOBIAS: "Due to a defect in the
central respiratory system."

THE COMMISSIONER: Yes.

MR. TOBIAS: "... the infants go
into prolonged periods where they
stop breathing which ultimately
leads to death."

So that simply put the theory is that it is basically
a problem with breathing, they stop breathing.

THE COMMISSIONER: They have trouble
with the central respiratory system?

MR. TOBIAS: Yes.

THE COMMISSIONER: Something wrong with
their breathing?

MR. TOBIAS: That is correct.

THE COMMISSIONER: That is what the
theory is?

MR. TOBIAS: Simply stated that is
what the theory is.

THE COMMISSIONER: Yes, all right.

MR. TOBIAS: And the authors of this
article say:

"The apnea theory is accepted as a
working hypothesis by a large number



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2 "of research groups around the world.
3 It does have a substantial body of
4 supportive data, obtained in several
5 scientific disciplines. There are
6 reports of a small number of infants
7 with convincingly documented prolonged
8 apnea who later succumbed to SIDS.
9 Despite this, in most SIDS infants
10 proof of this hypothesis is lacking."

11 And my only question to you, Doctor,
12 was you informed that you can't comment on that, you
13 can't agree with that because you haven't read the
14 literature, and I accept that. Is it also valid to
15 say that you can't disagree with it?

16 THE WITNESS: That is right.

17 MR. TOBIAS: Q. Because you haven't
18 read the literature?

19 A. I make no comment on that in
20 answer to that question.

21 Q. Fine, and I accept that. I would
22 ask you the same identical two questions with respect
23 to the next reference which appears on the same page
24 Mr. Commissioner, if you look at the middle column
25 the third paragraph down:



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G 7

"The possible role of cardiac conduction defects, arrhythmias and the prolonged Q-T interval syndrome is a controversial one. The literature on this subject is reviewed by Valdes-Dapena, who concludes that Q-T prolongation is not a factor in SIDS: nevertheless, conduction disorders, which require treatment if sudden death is to be prevented, can occasionally present at this age."

Doctor, the same identical question, can you agree with that statement, do you support it?

A. Here again you are asking me a direct question that requires a knowledge of the literature on SIDS and this is not my field.

Q. All right. I take it that means you can't agree with it?

A. And I can't disagree with it.

Q. And you can't disagree with it?

A. Yes.

Q. That's all I want to get at.

MR. SCOTT: He doesn't want to say.

THE WITNESS: I don't want to say anything about that.



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MR. TOBIAS: Q. Okay, I recognize that Doctor. I will ask you the same question one last time and one last time only, and that refers, and I am referring now specifically to the first article that I put to you which is the British Medical Journal article, and I am now referring to, on the printed material Mr. Commissioner, page 1095.

THE COMMISSIONER: 1095?

MR. TOBIAS: Starting with the last full sentence on that page: "Nevertheless ...".

THE COMMISSIONER: 1095, oh yes.

MR. TOBIAS: Which will be the second last page, and it starts with the word "Nevertheless".

THE COMMISSIONER: Where do I find that?

MR. TOBIAS: In the last column, the third line up:

"Nevertheless, none of the infants who suffered the Sudden Infant Death Syndrome showed prolonged intervals compared with control values obtained with the Medilog recorder; this indicates that a single measurement of the Q-T interval from the 24 hour recording was not predictive of the Syndrome."



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And then later on down on that page, the third paragraph that starts:

"In conclusion, the Sudden Infant Death Syndrome was not predicted by the presence of prolonged apnea or disorders of cardiac rhythm or conduction on 24 hour tape recordings taken during the first six weeks of life; these results neither confirm nor negate the possibility that these disorders occur just before death in this Syndrome. This study does suggest, however, that prolonged apnea sometimes detected after a near miss episode may be the consequence of the episode rather than the cause."

Now, with respect to both of those statements would you answer to me be the same, that because this is not your field and because you haven't read the article or the literature you can neither agree with those statements nor can you challenge them?

A. No.

Q. You can't help me with them at all, can you?



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A. No, you will have to have someone else deal with this particular --

MR. SCOTT: I take it the Doctor says that he can neither confirm nor negate, and therefore as the Doctor can neither confirm nor negate I take it he can agree with the theory?

MR. TOBIAS: Well, I think that is.

THE COMMISSIONER: Well I would rather he didn't agree with the theory because I don't quite understand it.

MR. TOBIAS: I was about to say, Mr. Commissioner, I don't think that is quite what the authors say. What it does say is that they suggest, or rather they say the results neither confirm nor negate "the possibility that the disorders occur just before death", that is all.

THE COMMISSIONER: I don't really think that we have got much in this line of cross-examination, that we have much to help us.

MR. TOBIAS: No, I agree Mr. Commissioner, you will be pleased to know that I agree with you fully and was about to move on to the very last area that I want to get into.

THE COMMISSIONER: Yes, all right, thank you.



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G 11

MR. TOBIAS: Q. Now I understand from Dr. Rowe's evidence, and I am referring to the evidence he gave in Volume 17 at page 2871-2873, and I am going to summarize it rather than reading it verbatim.

That Dr. Rose thought that what she was dealing with here she suspected it might be a viral infection affecting the heart muscle, and that the preliminary autopsy report, even after it was available, and I understand she actually saw the autopsy done, still didn't rule out that possibility. It was therefore decided to await further results of the microscopic examination before this case was reported to the coroner?

A. Yes.

Q. Because she felt that those results might in fact give her an adequate explanation for death?

A. Yes.

Q. And that was in spite of the fact that this was a sudden and unexpected death and the Coroner's Act requires such a death to be reported. In fact, Dr. Rowe's evidence was it was a judgment call, and in reviewing it in hindsight it might have been a bad judgment call, but he acknowledges that is a judgment call and that was our judgment.



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I just wanted to know were you privy to the discussions ongoing at that time, did you have any input whatsoever into the decision of whether or not to report this case to the Coroner immediately, or to await the results that Dr. Rose wanted?

A. I don't remember specific discussion with Dr. Rose, but you are going to be talking to her tomorrow, or whenever, but I do not specifically remember deciding with her that this should not be sent to the Coroner.

Q. Did you discuss this question at the time with Dr. Rowe as well as Dr. Rose?

A. I can't remember that either.

Q. Wouldn't it be somewhat unusual, please help me on this because I am unsure myself of the procedure, the fact that you were the ward chief --

A. Yes.

Q. And in fact were the physician responsible for the care and management of Jordan Hines?

A. Yes.

Q. Would you not have had to have some input as to whether or not the case should be reported to the Coroner, was that not discussed with the attending physician?



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A. Yes. I think we must have discussed that either individually, or at our conference, the next conference we had first thing in the morning.

Q. So it is not possible that that decision would have been made arbitrarily by Dr. Vera Rose without consulting you?

A. I would think that was unlikely but I don't remember the specific part. I think that it is likely that she did discuss that with other people but you should ask her.

Q. What I am really getting at is this: is it at all possible that she could have failed to report it if you had wanted it or insisted that it be reported?

A. Oh, no.

Q. Who makes the decision Doctor?

A. We don't have conflicts usually. We discuss things and we don't have fights of that sort, and they are always, in our department they are always settled. If I said it should be done and she said, no, let's not bother, then I am sure that I would have suggested that she get in touch with the Coroner and that was not done at that time.

Q. All I am trying to determine now



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is in a situation where there is no conflict.

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A. There is no what?

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Q. In a situation where there is
no conflict.

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A. Yes.

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Q. There is no question that it
should be reported?

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A. Yes.

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Q. If you and the other doctors
agree?

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A. Yes.

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Q. Who is it that sees that it gets
reported, is it the attending physician, is it the
ward chief, is it the clinician who treated the child
at the time of the arrest, is it the chief of
cardiology, whose responsibility to see that once the
decision is taken to report that it gets reported?

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A. I think that would either be the
person who was on duty at the time it occurred, that
is an acute thing and you make a decision then, or in
consultation and the next day or so it is done with
the ward chief; or it would be either the person on
duty at the time or it would be the ward chief, and
if there is conflict or discussion we would go to
Dr. Rowe.

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Q. Now given the state of your memory all we know is this, we know it wasn't reported?

A. Yes.

Q. We know that it is highly unlikely that Dr. Rose would not have reported it had you insisted that it be reported?

A. Yes, that is right.

Q. So obviously you were not insisting that it be reported?

A. Of course not.

Q. Therefore, you concurred obviously with her judgment not to report it?

A. Yes.

MR. TOBIAS: Okay, those are all my questions, thank you, sir.

THE COMMISSIONER: Thank you Mr. Tobias. Mr. Labow?

CROSS-EXAMINATION BY MR. LABOW:

Q. Doctor, I would like to start off with some general questions before I deal with specific children.

A. Yes.

Q. Can you tell me what you feel are the responsibilities of a ward chief at the Hospital



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for Sick Children?

A. He is the attending physician and he has to direct the treatment of the patients on the cardiac ward.

Q. Now when a child is admitted to the ward when you are the ward chief, could you outline for me generally what would happen, would you do the original consultation?

A. Generally speaking I would. I would try to, within 24 hours, as you know the resident would do a history and then the cardiac fellow would discuss it with him, and if there is some very acute thing I would come right away and do a consultation, usually within 24 hours I try to have a consultation on the ward, and in the usual case that is done.

Q. If it is an emergency case or something very acute you try to be there very quickly?

A. Yes.

Q. But you would do a consultation in any case within 24 hours?

A. Yes, I see the patient having in hand all the information that has been secured, collected by that time by the people on the ward.

Q. In the day to day care of a



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patient who is in the ward when you are the ward chief
how much contact would the ward chief have with the
patient?

A. We make regular rounds with the
residents, cardiac fellows and someone from - certain
nursing staff, twice weekly at a certain time, and
another time, so this will be the third time I go
around in addition with all those people with the
cardiac surgeon. So in actual fact I actually go by
the bed of each of the patients on the ward three
times a week.

Now of course this is the routine
working rounds of course, and a few things naturally
in between times I will go to the ward and deal with
the problem.

Q. Now during the preliminary
hearing you were asked similar questions, and this is
page 22 and 23 of Volume 19 and you pointed out that
the ward chief had the ultimate responsibility for
all the patients?

A. Yes.

Q. So you agree that is the case,
that as ward chief you would have ultimate responsi-
bility for the care and management of any patient on
the ward at the time?



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A. Unless it was a patient that was a surgical patient, and this is a combined medical/surgical ward, and approximately 50 percent of the patients on that ward are - the ultimate physician that is directing their care is the surgeon who is doing or planning to do the operation. However, the surgeons are in the operating room a lot of the time and I take responsibility for all the medical problems that occur even on the surgical patients on the ward, but the surgeon who did the operation is in actual fact, is the physician in charge, the ultimate physician that is related.

Q. Is that throughout the child's stay once the surgery is completed?

A. Yes.

Q. The surgeon in charge still has ultimate responsibility?

A. Yes, but as I say most of the problems that occur in the postoperative period are medical ones and we have a good relationship with the surgeons and they are very anxious that we participate in the care to the point of taking responsibility for medical problems in their surgical patient.

Q. Now we have heard a lot about the common symptoms of digoxin intoxication.



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A. Yes.

Q. Now Dr. Freedom in Volume 29,
and I don't have the page, answered a question
affirmatively that common symptoms were arrhythmias,
bradycardia, vomiting, ventricular fibrillation,
heart block and DKG changes.

A. Yes.

Q. And added in, increased lethargy,
yellow vision and psychosis.

A. Yes, those are very rare
particularly in infants.

Q. The last three?

A. The last three.

Q. Are they rare because you can't
really determine them?

A. I suppose it is pretty hard to
get a baby to tell you whether he has got yellow
vision or not, but I think those neurological problems
are relatively unusual in intoxication with digoxin.

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Q. Now, Dr. Rowe in Volume 24 at
page 4351, indicates that the most common symptoms
are vomiting, diarrhea and irregular heart action.

A. Yes.

Q. Do you agree with all of those?

A. I would have thought that
vomiting or that diarrhea is not as nearly as common
as the other two in digoxin intoxication. That can
certainly occur.

Q. So, it can occur but it is not
one of the common symptoms?

A. Not as common as the other two
that you mentioned.

Q. Okay, Doctor. In your article,
Exhibit 174, you referred to a number of other
symptoms that you observed in the readings and in
your observations for that article?

A. Which paper is that now?

Q. This is the paper written
"Accidental Digitalis Intoxication in Children".

A. Yes, okay, fine.

Q. In 1964.

A. Yes, right.

Q. At page 195 you refer to
neurological problems.



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A. Yes.

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Q. And although they are not common

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in children you have just told me they are drowsiness,

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irritability, restlessness, disorientation, temporary

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amnesia, and a couple of others?

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A. Yes.

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Q. You also refer at page 198 to

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vomiting and slow and irregular pulses. These are

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in your conclusions at the very end of that page.

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A. Yes.

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Q. As well as drowsiness?

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A. Yes.

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Q. And then at the top of the next

page, sinus bradycardia, exaggerated sinus arrhythmia

and AV block?

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A. Yes.

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Q. Now, page 197 of that article

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you comment that calcium and digoxin reacts synergis-

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tically?

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A. Yes.

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Q. Could you explain that to me,

please?

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A. Well, they have similar effects

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on the contractility of the heart and there is a fair

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bit of work that suggests that calcium shifts in the

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myocardium and are related to the action of digoxin and digoxin gets bound to the heart muscle and then its action is to have some effect on the shift of calcium in and out of the compartments in the heart.

Q. Now, I'm not sure I understand. Would that mean that the digoxin would react in a stronger way if the baby was receiving calcium at the same time?

A. I think it's much more subtle than that. I can't explain the biochemistry of what's going on but I think that the calcium and digitalis have some effects on contractility and function of the heart.

Q. Well then, would that mean if a child was receiving calcium.

A. Yes.

Q. And receiving digoxin.

A. Yes.

Q. Then you would lessen the dose of digoxin?

A. This isn't quite as clear as it is in other situations in terms of electrolytes and potassium is the one that we are most concerned about. I think that we would perhaps look at the situation but I think it isn't nearly as clear that



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potassium or calcium and digoxin are not, they have the same general effect but it isn't just a matter if you put one up the other has to go down, it is much more complex than that.

Q. Okay. My question really bases on my understanding of what synergistically means?

A. Yes.

Q. I was under the impression that an equation for synergy would mean 1 plus 1 is 3 rather than 2.

A. Yes. Well, I think it is much more complex in this particular situation that you are talking about.

Q. Thank you, Doctor.

Now, in preparing for this Commission and reviewing - and I am assuming that you reviewed in some way the children that you were responsible for or had some contact with.

A. Yes.

Q. Could you outline for me what you reviewed in order to come here to testify. For example, did you review the Hospital records?

A. Yes. This of course is the key to the whole thing was that we would review the 36 patients. So, we divided this up among our



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colleagues and we tried to review the ones that we were related to because sometimes somebody else reviewed the patient that you end up having to discuss. But at any rate, the Hospital charts were reviewed in great detail by some member of our cardiac staff and we then made some summaries of what we thought were the important things and then these were distributed to everybody and we got consensus about what is important and then from then on I have had to refer again to the Hospital charts in many cases where I know that I am going to be asked to talk about what is going to happen.

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Q. Now, did that mean you may have reviewed summaries as well as the charts that you didn't prepare, that someone else prepared?

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A. Yes. I think generally speaking though some place along the way, because I have done this repeatedly in the last few weeks, I probably have reviewed the Hospital charts of the patients that I'm involved with, but I can't be a hundred per cent sure, but I certainly have reviewed the summaries of every patient.

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Q. Now, I understand from your previous testimony you have reviewed Dr. Rowe's testimony given to date?



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A. Yes, I have tried to review that. I perhaps haven't read every single page of that but I have tried to get the substance of what he was saying.

Q. Have you discussed the Commission with Dr. Rowe?

A. Oh, yes.

Q. Recently?

A. Oh, yes, of course. We discuss his evidence each time he comes back to the Department and we go over it.

Q. So, I am primarily interested in four patients that you had some contact with.

A. Yes.

Q. That's Paul Murphy, Kristin Inwood, the Lutes baby.

A. Yes.

Q. And the ...

A. Gionas?

Q. The Gionas baby.

A. Yes.

Q. Have you discussed those children with Dr. Rowe?

A. I may well have, yes.

Q. Recently?



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A. Yes.

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Q. Do you have any - I'm sorry.

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A. I don't really know. I think

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if you question Dr. Rowe about that then I may well have discussed it with him.

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Q. No, I am asking you because

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you are here.

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A. Yes, yes.

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Q. Do you know by any chance, and

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I don't know if you do, whether the summaries that

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you reviewed of those four children were summaries

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that you prepared or someone else prepared for you?

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THE COMMISSIONER: I'm sorry, the

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summaries?

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MR. LABOW: He referred to the

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summaries that the doctors prepared.

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THE COMMISSIONER: Oh, I see.

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MR. LABOW: I would like to know if

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they were summaries that he prepared in these four cases or summaries that someone else prepared?

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THE WITNESS: I can find out if that's

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important to your questioning.

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MR. LABOW: Q. I would like you to

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find out over lunch if you can.

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THE COMMISSIONER: Well, but he said

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if it is important.



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THE WITNESS: Is that important because the summaries were prepared and discussed with the whole staff and they were supposed to include all the important details.

MR. LABOW: Q. Well, did the summaries also include opinions expressed by the doctor who was drawing them up as to what was happening at the time?

A. Yes, yes. The last little paragraph of it was what the person who did the summary said at this time, what his judgment was of what went on.

Q. Well, I would be very interested to know what those judgments were in those four cases.

THE COMMISSIONER: Well, you can ask I suppose.

MR. LABOW: I definitely intend to, Mr. Commissioner.

THE COMMISSIONER: Yes, yes, all right.

MR. LABOW: Q. Now, aside from reviewing this with the cardiologists ---

THE COMMISSIONER: I am not sure though that if you are asking for the production of the documents themselves.

MR. LABOW: Well, I'm not sure if I'm going to ask for it yet.



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THE COMMISSIONER: Well, yes, but if you want to know what the things are, you perhaps will ask him now so that he can then get it.

MR. LABOW: Well, if possible, I would like the summaries for those four children produced so that I can review them.

THE WITNESS: Yes. Well, we prepared these for Mr. Ortved and I presume, I don't know whether there is any reason why you can't see them.

THE COMMISSIONER: Well, I trust that this will be passed on to Mr. Ortved wherever he happens to be lurking at the moment so that he can take a stand this afternoon.

MS. CHOWN: Yes.

THE COMMISSIONER: Or you can take a stand on his behalf.

THE WITNESS: I think in actual fact Mr. Ortved was not averse to letting other counsel see these because there is nothing incriminating in them at all.

MR. LABOW: I'm sure there isn't.

THE COMMISSIONER: Even if there isn't sometimes they may not be that ...

THE WITNESS: I see.

MR. LABOW: Q. Now, aside from the



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statements that you gave to the police that we have already heard about, did you give statements to anyone else regarding this matter, regarding the deaths of these children?

THE COMMISSIONER: You mean did he discuss it with his wife and that sort of thing?

MR. LABOW: No, no, I am referring to formal statements.

THE WITNESS: Well, I think all the statements that I - well, there were so many people involved in looking at our unit in the last year, like, there was the Dubin Commission and all sorts of people come around and want information. I normally - and I have the statements that I made to the police on various occasions and I don't think, I can't remember all the different people that came around wanting information, so, I can't tell you.

MR. LABOW: Q Well, did you have any input into what was being investigated into by the people from Atlanta?

A. No, no, not at all. No, Dr. Rowe was the person who dealt with that particular group.

Q All right.

A. And I don't think - they might



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have asked me about some general things but I don't
remember them going into any specific cases with me.

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Q. That's fine.

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Now, we are well over two years since
the last death with which we are concerned with.

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A. Yes.

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Q. Could you tell me when you were
first asked to review the matters that we are involved
with here?

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THE COMMISSIONER: I don't know
whether he could answer that question, I couldn't.

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THE WITNESS: I can't.

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THE COMMISSIONER: When he reviewed
the matters, what do you mean by that?

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MR. LABOW: Well, when you began to
review all these deaths as a group?

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THE WITNESS: Well, I suppose for
the preliminary hearing, and I can't remember all the
preparations that went into that. We may well have
gone over many of these patients at that time.

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MR. LABOW: Q. But other than that,
you are not exactly sure?

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A. No.

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Q. Now, the first child I would
like to deal with is Paul Murphy.

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A. Yes.



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Q. Now, in Paul Murphy's case you
were the referring physician?

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A. Yes.

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Q. Is that correct?

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A. Yes.

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THE COMMISSIONER: Referred or
referring, which is it? Referred to you, is it?

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THE WITNESS: Yes, and then I followed
him as an outpatient and then, so, I am quite familiar
with him.

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THE COMMISSIONER: Yes. Are you
described as the referring? I would have thought the
referred?

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THE WITNESS: No, he was referred to
me by a general practitioner.

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THE COMMISSIONER: And that would be
the referring physician?

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THE WITNESS: Yes. And then after
that then I am the referring cardiologist, if you like,
and then every time there is a problem I have to deal
with that as an outpatient.

19

20

21

THE COMMISSIONER: I am just having
trouble with the English language. Whom are you
referring it to? You are referred, aren't you?

22

23

THE WITNESS: Yes, it was referred to

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me as an outpatient and then I refer it to the ward chief if he has to be sent in the Hospital. So, I am then the referring physician rather than the referred.

THE COMMISSIONER: I see, all right. What did you mean when you asked him if he was the referring physician?

MR. LABOW: Well, I am going to ask him right now.

Q. Were you the referring physician who had the general control of what happened to Paul Murphy?

A. Yes.

Q. From 1965?

A. Yes, yes. As I remember it I looked after him all that time.

Q. So, you looked after him over the 15 years?

A. Yes. I am pretty sure that I looked after him right from early life.

Q. Now, Paul Murphy was ill since birth and the cardiology staff at the Hospital had determined that his cardiac condition was no longer operable?

A. Yes. He had had, as you know,



H.14

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several operations, but he reached the stage when
there was nothing further that we could do.

4

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6

Q. Now, on his final admission,
and I am only referring to his admission on the 19th
of August, 1980.

7

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9

A. Yes.

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11

12

Q. I seem to remember you saying
in your testimony where you added in the fact that he
was suffering from a neurological condition.

A. Yes.

11

12

Q. That this admission was for a
neurological evaluation.

13

14

A. Yes.

15

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Q. Now, I must tell you I have been
unable to find any note of that in his chart.

A. Yes.

16

17

18

Q. In his Hospital record, excuse me.

A. Yes.

19

20

Q. And if you could find it for me
I would appreciate it but I would like to refer you
to, first of all, page 17 of Exhibit 80C.

A. Yes.

21

22

23

Q. Wherein in your letter in mid-
September to Dr. Dennis.

A. Yes.

24

25



H.15

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Q. And I am assuming Dr. Dennis
is the family physician?

4

A. Yes.

5

6

Q. You claim, in the second
paragraph, that - or the first paragraph that he

7

" ... was admitted to hospital for
adjustment of his medications ... ".

8

A. Yes, that's right, and he died.

9

10

Q. Was he admitted for adjustment
of his medication?

11

A. Yes.

12

13

Q. What was wrong with his
medication?

14

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A. Well, the fact that he was in
dreadful heart failure and his heart failure was
getting worse and he was developing neurological
problems; in other words, he was having these abnormal
movements and getting a little bit difficult to rouse
sometimes and so on. So, he was admitted to adjust
his medication in an attempt to improve his heart
function which would secondarily improve his cerebral
problems.

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Q. Well, at page 118 of the
Hospital record, Dr. Jedeikin in the discharge report
that he writes, claims that, in the second paragraph:



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"This admission was due to the
appearance of lethargy ... "

and vomiting and also the involuntary movements and
grimacing that you referred to?

A. Yes.

Q. Now, are the lethargy and
vomiting only related to the neurological problem?

A. Yes.

Q. Or could there be another
problem?

A. No, that could be due to the
fact that he had - I think he was originally thought
to have hydrocephalus in which there is an increase
in fluid in the inside of the brain and this was, as
I understand, all right, but as I understand he was
a bit slow in his mental development and then the
problem here I think is probably due to the effects
of his heart failure.

Q. Fine. Now, you had been in
contact with this boy for almost 15 years?

A. Yes.

Q. What was he generally like; not
medically necessarily. I know this seems a strange
question, Mr. Commissioner.

THE COMMISSIONER: In what way, what
do you mean?



H.17

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2

MR. LABOW: Q. Was he friendly?

3

A. Oh, yes.

4

Q. Was he nasty?

5

A. No, no, no. He was a very pleasant child.

6

Q. That was my understanding.

7

Now, the progress notes begin on page 124 and on that page, on August 19th, the day of his admission, it notes that he had two episodes of nausea.

10

11

A. Which page do they start on?

12

Q. The progress note, page 124.

13

A. 124?

14

Q. I'm sorry, it is 126. I don't have any final numbers on mine.

15

A. I can't see that.

16

THE COMMISSIONER: Are you saying the one that looked pale or something like that?

18

MR. LABOW: Looked pale.

19

THE COMMISSIONER: Pale with blue extremities?

20

THE WITNESS: Oh, I see, all right.

21

THE COMMISSIONER: Have you found it?

22

THE WITNESS: All right.

23

MR. LABOW: Q. About five lines down

24

25



H.18

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2

there is reference to two episodes of nausea.

3

A. Yes.

4

Q. And at page 142 there is just

5

a reference to a digoxin level that was taken at 10:45
that day, on the day of his admission, and it was

6

1.8.

7

A. Yes.

8

Q. Now, in the preceding days, or

9

the following days, on the 20th of August he exhibited

10

a persistent confusional state; that's on the same

11

page.

12

A. Yes.

13

Q. Second line of the next note.

14

A. Yes.

15

Q. And on the 21st he was still

16

somewhat confused and he was also drowsy.

17

A. Yes.

18

Q. And that's pages 127, the second

19

note points out that he was confused; page 129 which

20

refers to him being drowsy and easily aroused when
disturbed.

21

On the 22nd of August he continues

22

to exhibit some symptoms and he is vomiting and on

23

the 23rd of August, this is page 130.

24

A. Yes.

25

26



H.19

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2

Q. In the middle note:

3

"He is confused and disoriented."

4

The nurse notes that his father states that:

5

" ... he has 'yelled out at me twice
today and that's so unlike Paul'."

6

A. Yes.

7

8

9

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I/EMT/ko

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Q. That night at about 10:25 p.m.

3

his terminal events begin and he dies?

4

A. Yes.

5

Q. Now in your article, Exhibit

6

174, you refer to, and I have already referred to,
neurological symptoms.

7

A. Yes.

8

Q. Of digoxin toxicity?

9

A. Yes.

10

Q. Now this is one of the few cases

11

where neurological symptoms may be exhibited because

12

we are dealing with a 15 year old boy.

13

A. Yes.

14

Q. Now he is confused, disoriented,

irritable, which is unlike him according to his father.

15

A. Yes.

16

Q. And to your understanding of what

17

he is like. And he also vomits often.

18

A. Yes.

19

Q. And I suggest to you that these

20

are clear indications of digoxin intoxication; not

21

necessarily only digoxin intoxication but based upon

22

your article and what we have already heard, clear

23

indications that that was possibly the cause of the

24

terminal events?

25



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I 2

2

A. No. I wouldn't agree with that

3

in this child.

4

Q. Why not?

5

A. Because he had these symptoms

6

that could be due to digoxin intoxication, but he was

7

terminally ill. The circulation to his brain was very

8

inadequate because his heart wasn't pumping blood out

9

effectively, and I think that his death was the result

10

of his severe heart failure affecting his cerebral

11

status and also the fact that he has had this previous

12

problem in infancy of the development of his brain.
So that this was much more likely the explanation of
those symptoms.

13

Q. Much more likely? The digoxin

14

intoxication was not looked into as a possible cause?

15

A. No.

16

Q. Notwithstanding the symptoms he

17

exhibited?

18

A. No. That is true because he was

19

a terminally ill child and he was sent in to the

20

hospital expecting that he probably was going to die

21

of his heart failure at that time.

22

Q. I understand that, and I under-

23

stand your letters painted a very gloomy outlook and

24

I have reviewed them all.

25



I 3 1
2 My question is if he exhibited these
3 symptoms, notwithstanding that it might have been more
4 likely that he died from his general health problems,
5 why did the hospital not investigate, possibly do one
6 digoxin post mortem reading?

7 A. Well, I am not sure when did he
8 die?

9 Q. He died on the 23rd of August
10 in the evening.

11 A. Of '80?

12 Q. Of '80.

13 A. Well, because of the time that
14 he died, this wasn't a routine thing at all to do
15 digoxin levels in people that die, particularly people
16 who are expected to die who had serious heart problems.

17 MR. LABOW: Is this a suitable time
18 to break?

19 THE COMMISSIONER: Yes. Can you help
20 us out as to how long you think you will be?

21 MR. LABOW: I expect to be about an
22 hour.

23 MS. CRONK: In total, Mr. Commissioner,
24 or yet?

25 MR. LABOW: An hour yet; possibly a
little less than an hour.



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MS. CRONK: Under the circumstances,
Mr. Commissioner, I know it is Mr. Lamek's present
view that he expects to be 15 minutes to half an
hour in re-examination.

Might we excuse Dr. Rose?

THE COMMISSIONER: Yes. I think so.
I think we will do that.

Then until 2:30.

--- Luncheon recess

- - - -



/ENT/ak

1
2 ---Upon resuming at 2:30 a.m.

3 THE COMMISSIONER: Yes, Mr. Labow?

4 MR. LABOW: Q. Dr. Fowler, do you
5 have the summaries that we were discussing previously
6 with you on the four children that I am concerned
7 with?

8 A. Yes. Yes, I have. We have
9 dealt with Paul Murphy I guess, have we?

10 Q. I haven't completely finished,
11 but I would like to see the summaries.

12 THE COMMISSIONER: Have you a
13 position?

14 MS. CHOWN: Yes. Well,
15 Mr. Commissioner, it is my position and I unfortunately
16 have not been able to track down the elusive
17 Mr. Ortved but as I understand it these summaries
18 were prepared for the assistance of counsel in
19 preparation for this Inquiry and that they should not
20 be produced. I am in your hands.

21 THE COMMISSIONER: Well I think I
22 can take that as an objection.

23 What do you have to say, Mr. Labow?

24 MR. LABOW: Well, I would like to
25 ask the Doctor a question.

Q. Can you tell me when these



1
2 were prepared?

3 A. They were prepared within a
4 month or so prior to the beginning of these hearings,
5 and they include generally only material that is
6 found in the hospital chart.

7 Q. And they were circulated to
8 the doctors?

9 A. Well, all the cardiologists
10 who are involved in this hearing, and we sat down
11 with each other and decided - made sure that the
12 facts as everybody knew them were correct in the
13 summaries, and so each of us used these summaries
14 to prepare in addition to going back to the charts.

15 MR. LABOW: Well, Mr. Commissioner,
16 I would say that they are highly relevant in that
17 the doctor has already --

18 THE COMMISSIONER: They may be
19 if
20 relevant but I think/they were prepared in connection,
21 if you would like to call this, litigation, I would
22 hesitate --

23 MR. LABOW: Well, I would question
24 whether the privilege that would apply in a normal
25 trial situation would apply in a Commission.

THE COMMISSIONER: I think that is
exactly what the Statute says. I think it does apply.



1
2 All privileges apply, if it is a privilege it applies
3 in this as well as any other.

4 I don't think I will order them to
5 produce them, particularly as Mr. Ortved it doesn't
6 seem to me has been informed about this, and he
7 will hit the roof if he hears that this has been...
8 So I don't think I will make the order.

9 You may find that he is quite
10 willing to give them to you, though.

11 MR. LABOW: Well, by then it would
12 be too late.

13 THE COMMISSIONER: Well, it won't be.

14 MR. LABOW: It will be too late for
15 me concerning this Doctor and these children.

16 THE COMMISSIONER: Well, that may be.

17 MR. SCOTT: It would save a trip to
18 the shredding machine for me.

19 MR. LABOW: Q. Doctor, we were
20 discussing Paul Murphy and we had gone through the
21 symptoms, notwithstanding the fact that many of the
22 symptoms were very similar to symptoms of digoxin
23 intoxication, you told me that you felt that the
24 death in this case could be held to be from "natural
25 causes".

A. His severe --



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Q. His clinical condition?

3

A. Yes. Congestive heart failure.

4

Q. Now if that is the case - first

5

of all do you agree with me that many of these

6

symptoms were symptoms that would be found with

7

digoxin toxicity?

8

A. Yes, that is true.

9

Q. Now my question to you is

10

in a case such as this where you can say that the

11

child in question, or in this case the boy in

12

anatomical causes, does that mean even if he exhibits

13

symptoms of another form that might lead to another

14

conclusion, you ignore it completely?

15

A. It depends on the severity of

16

his illness and he was - it was expected that this

17

boy was going to die within a few days or certainly

18

a week or two as all my letters have suggested at

19

this time. And I think that it would be reasonable

20

to not investigate many other diseases that might be
going on if he is pre-terminal.

21

Q. So it is the practice -

22

depending on the patient, it is the practice at the

23

Hospital to not look into it any further.

24

A. If a patient is obviously

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going to die.

Q. But we didn't know when this patient was going to die.

A. Well, he looked like he was going to die any minute.

Q. When was the last time you had seen him prior to his death on the 23rd of August?

A. I can't tell you.

Q. You don't have any idea when you had last seen him?

A. No, I don't. I haven't a note that I have noted on the chart. I suspect that I didn't see him during that hospital admission, but I might have, and I might well have dropped in, although Dr. Freedom was the physician in charge making the decisions on his treatment, I quite often just to talk to the parents, often drop in, and particularly in this situation where a child is at the point of expiring, to talk to the parents and try to comfort them a little bit.

Q. Now, Doctor, we have gone through the symptoms and signs of digoxin toxicity.

I would like to put a hypothetical to you that was previously put to Dr. Rowe, and I am not sure if you read this carefully when you read



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2 over his evidence or not. But Mr. Manning's hypo-
3 thetical was if you knew that a patient had a heart
4 problem, was being given digoxin and diuretics and
5 you knew nothing more about him, saw vomiting or
6 sickness or giddiness, what would be your first
7 diagnosis?

8 A. Yes, if I knew that he was
9 receiving digoxin I think I might suspect that we
10 would have to look into digoxin.

11 Q. And that would be one of your
12 primary concerns?

13 A. That would be a concern, but
14 mind you, we are not talking - we are talking about
15 another patient; not this patient who has major
16 neurological problems, so you are talking about a
17 hypothetical.

18 Q. Hypothetical.

19 A. Hypothetical case.

20 Q. Absolutely. But we know this
21 patient has major neurological problems but we also
22 know that based upon your article, some of these
23 neurological problems could be caused by digoxin
24 toxicity.

25 A. They could.

Q. So we couldn't rule that out.



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A. But in actual fact on the 19th of August he had a digoxin level which was 1.8 which is well within the therapeutic range.

Q. Right. That was on the day of his admission?

A. Yes.

Q. But over the next four days until his death no levels were taken or ordered?

A. No.

Q. Now one would think just as a general situation, it is my understanding that a doctor would have to request a digoxin assay?

A. Yes.

Q. They are not taken as a course?

A. No.

Q. And they weren't at that time?

A. No.

Q. As ward chief could you do that for any patient on the ward?

A. Of course. If this was indicated to do it this would be one of your jobs.

THE COMMISSIONER: I would think you could do it whether it was indicated or not.

THE WITNESS: Of course.

THE COMMISSIONER: But you wouldn't



AA8

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2 do it unless it was indicated.

3 THE WITNESS: Yes, that is right.

4 MR. LABOW: Q. Thank you, Doctor.

5 I would like to go on to the Lutes
6 child, Matthew Lutes. The Hospital record is Exhibit
7 69.

8 Now, Doctor, you were the ward chief
9 in November?

10 A. Yes.

11 Q. This child was transferred
12 from Sault Ste. Marie on the 12th of November?

13 A. Yes.

14 Q. Do you know when you first
15 saw him?

16 A. I can't tell you, but I may
17 have a consultation note here which... I saw him on
18 November 12th. I don't have the time. That was the
19 date of admission.

20 Q. And on the day of his admission --

21 A. Yes.

22 Q. -- he had a cardiac catheteriza-
23 tion. And according to a note on page 75 in the
24 medication record --

25 A. Yes.

Q. -- on the day of his admission



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at 9:00 p.m. digoxin was held. And a digoxin level was ordered next day at 10:30 a.m.

A. Yes.

Q. Is this standard for someone who is admitted to the Hospital and on digoxin therapy?

A. There may have been some - he presumably was on digoxin when he was admitted to the Hospital.

Q. Yes.

A. And if there was - some residents would do that routinely; many others would do that if there was some suggestion that there had been toxicity previously.

Q. Well, as ward chief would you routinely order a digoxin level after you had seen the patient who came into the Hospital?

A. No. Not routinely unless it was indicated.

Q. Now you have indicated previously in your testimony that you thought the level should be kept somewhere under 2 nanograms per millilitre?

A. Yes. Well, as you know, - I don't know whether you have been here for some days.

Q. I have.



Fowler, cr.ex.
(Labow)

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A. This was discussed, and this is a guideline, and I'm sure that Dr. Rowe pointed out to you a very good editorial in the New England Journal suggesting that 2 is the lower limit where you could expect to have any type of toxicity, and you can have levels up to $3\frac{1}{2}$ or something like that, or 4, and having no evidence of toxicity at all. So you have a gray zone there. But 2 is the usual lower level.

Q. Had you ever seen toxicity at a level under 2?

A. No.

Q. Have you ever read of toxic effects with a level under 2?

A. I don't remember seeing that. Under ordinary circumstances. Now mind you if we have somebody with severe electrolyte upsets and poor renal flow and so on, this is conceivable.

Q. Now in this case from the 14th of November, on page 49 of the Hospital record this child had a digoxin level of 2.1.

A. Yes.

Q. And was continued on digoxin and diuretics.

A. Yes.



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Q. And that day he still continued to vomit and a digoxin level was ordered for the following Monday.

On the 15th of November he still continued to vomit, and on page 50 and 51 we have some notes dealing with the fact that his level was 2.1 but he was still vomiting feeds. He was still in congestive heart failure. He was very tired and a level was ordered.

Now on page 82 Dr. Eng - is that how you pronounce it?

A. Yes.

Q. Orders that digoxin be held tonight only. And on the following page there is an order given the next morning that digoxin be restarted.

A. Yes.

Q. Now, Dr. Rowe was asked why digoxin was held, in all fairness he answered, and this is on page 2437 that he speculated it was held because the child was vomiting.

A. Yes.

Q. Now you were the ward chief at the time. Can you tell us why you think it was held, or if you know?



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A. I can't tell you why. This must have been the order - the decision of a doctor who ordered it held.

5

Q. Well, that is --

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A. And he decided for reasons that I don't know, and I don't look over the shoulder of every resident every time he writes an order in the chart. He is responsible to look after the patients, and if he has questions in the treatment, then he would get in touch with me and we would discuss it, and I don't know, I may well have discussed that with him.

13

Q. You don't recall?

14

15

A. No, of course not. That is a long time ago.

16

17

Q. But as the doctor's with ultimate responsibility toward this patient --

18

19

A. Yes.

20

21

Q. -- at this time.

A. Yes.

Q. You may have discussed it.

A. It is conceivable, and I may not.

22

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Q. At page 2438 Mr. Lamek asked a question of Dr. Rowe:

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"Is there a suggestion that the vomiting may have been some indication that 2.1, although a barely elevated level, was perhaps a little too high for this child?

A. I presume that was the interpretation placed upon that."

Would you disagree with that?

A. I think that is a fair statement.

I would be very surprised if vomiting was the result of digoxin level of 2.1, and I am sure with all your discussions about the treatment of patients in congestive heart failure with severe congenital heart disease that in some situations you are into the situation that you have to give digoxin in order to help the heart action whether you think that it is a high dose or not.

But in this particular situation I think that one would think that he is obviously in terrible heart failure, and that is why we thought that he died, that to withhold the drug that is essential in the treatment of heart failure is not treating the patient correctly.

Q. Well, I would like to point out that with this child digoxin was held on the 15th



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2

of November.

3

A. Yes.

4

Q. And for the first time on

5

the 16th of November on page 53 of the chart the

6

child seemed to not exhibit any vomiting.

7

In the note between 0900 and 1900

8

hours there is no indication, although the child was

9

restless, that there was any vomiting and the apex

10

was regular and stable.

11

Then at 9:30 that day, digoxin is

12

apparently restarted, and on the 17th there is again
vomiting.

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DM.jc
BB

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The child is severely bradycardic according to the note on page 54 and the child dies.

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Now this child seemed to exhibit vomiting and other symptoms except on the day that digoxin was held, and then as soon as digoxin was once more started the child once more began to exhibit vomiting and other symptoms, and then died.

9

10

11

12

Now, notwithstanding that, I don't see any indication that anyone considered digoxin intoxication as a possible cause of death. Do you recall digoxin intoxication being considered as a possible cause of death?

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A. No, I don't. The vomiting is a very common symptom in childhood of many other things as well. I would think that if you have the proper dose of digoxin that he is receiving and you have a level of 2.1, and you stop it for 12 hours, then presuming the level is going to be a little less than 2.1, if you want to say it would then probably be lower than 2, the sort of cutoff point that would take another dose or two to get it up there again and I just can't conceive of digoxin toxicity being related to this child's death.

23

24

25

Q. Well, Doctor, we are dealing with a child who was not a long-term patient. This



BB.2

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child was only admitted to the Hospital on the 12th
of November.

3

4

A. Yes.

5

Q. And it died very early in the
morning on the 17th of November.

6

A. Yes.

7

Q. Now, this is not a Paul Murphy
situation, this is a situation where you are dealing
with a patient that you don't know very well. Now
this patient seems to have many of the symptoms
related to digoxin intoxication?

10

11

A. (a) vomiting.

12

Q. Yes.

13

A. Anything else?

14

Q. Well, there are not too many
symptoms here because we are only talking about four
or five pages of notes.

16

17

A. All right.

18

Q. But bradycardia just before death.

19

A. Yes.

20

Q. Which is another symptom, is it
not?

21

A. Yes, that is also a pre-terminal
symptom in people who die.

22

23

Q. I understand that. It is also

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BB.3

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a common symptom of digoxin intoxication?

3

A. Yes.

4

Q. Now notwithstanding that you

5

don't know very much about this child, and this

6

child does have that one indication; and in addition

7

the one day that digoxin is held the vomiting seems
to cease?

8

A. Yes.

9

Q. For the time being until it is

10

restarted?

11

A. Yes.

12

Q. You don't consider digoxin

13

intoxication as a clear possibility of the cause of
death in this case?

14

A. Absolutely not.

15

Q. Could you explain to me why?

16

A. Because the child has very

17

serious heart disease, and chronic heart failure that

18

is very difficult to control. I am not at all

19

surprised that this child succumbed to his disease,

20

and there is nothing in the chart that would suggest
digoxin toxicity.

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Q. Doctor, I would like to refer

22

to one short paragraph of Dr. Hastreiter - we had this

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problem the other day.

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BB.4

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THE COMMISSIONER: Did we make that
an exhibit?

MR. LAMEK: No, we didn't, sir.

THE COMMISSIONER: In the process that
I thought we went through ---

MR. LAMEK: I think we had better
think of doing that at the beginning of the week next
week, there was only a short reference to it yesterday
as you remember, sir.

MR. LABOW: This is a very short
reference.

THE COMMISSIONER: Yes, all right.

MR. LABOW: Q. Dr. Hastreiter reviews
this death, and at page 129 in his comments --

A. Yes.

Q. -- he does comment:

"That the clinical condition had
progressively deteriorated and that
his death was not unexpected ... "
but goes on to point out that it was:

"unusual for an isolated ventricular
septal defect to lead to death."

Do you not agree with that?

A. The trouble is that isn't what
he has, he has something much different than that.

Q. What does he have?



BB.5

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A. He has chromosomal abnormality,
a short arm five plus, which means there is something
wrong with your chromosomes.

5

Q. Yes.

6

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A. With a very serious sort of --
in terms of prognosis, he has a ventricular septal
defect. The most important thing of all that you
haven't mentioned is that he also has, which was
coarctation of the aorta which wasn't recognized.

10

Q. Until the autopsy?

11

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A. Until gross autopsy and the
stress of a volume load of the heart, of a big hole
plus a pressure load of a narrowing, that we didn't
recognize in life, but which he actually had, the
combination of the two things is often lethal. I am
sure that his heart disease and the accompanying
heart failure is the explanation for his death.

17

18

19

Q. Well, my next question leads
right from that. This child had a cardiac catheter
study done?

20

A. Yes.

21

22

Q. Is there any reason, that you
could think of, that the coarctation was not revealed
by it?

23

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A. I think this happens on occasion,



BB.6

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and I think that in very sick children often you don't like to give a large amount of contrast material in order to get all the abnormalities that are present, and that it isn't - we do occasionally miss coarctation in this situation, and this is one of the extreme examples.

Q. Now what kind of symptoms would a baby normally exhibit from the coarctation?

A. Severe heart failure.

Q. Other than that?

A. He will often have a difference in the blood pressures between the arm and the leg. I am not quite sure that was detected. Yes, the blood pressure in the right arm was 90, and in the left leg was 84, so the blood pressures are very close to being normal with the difference of a child that is struggling and crying and very sick, I could accept that as a clinical variation of dis-measuring. So that his blood pressures on the examination do not suggest coarctation of the aorta. The other thing is that we would like to feel the femoral pulses.

You have examined this chart, have I done a - yes, yes, here is my consultation note on November the 12th, and I said ---

THE COMMISSIONER: And the page number?



BB.7

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THE WITNESS: I am sorry, it is 56,
and if you look down, if you can read my writing and
I will interpret it for you because I am very poor:

"Femorals, radials and femorals
brisk but not hyperactive."

Some types of malformation will cause
very brisk pulses and you have seen examples of that
in truncus and so on. So these are my physical
examinations, it does not reveal coarctation of the
aorta. The blood pressure does not reveal it on the
physical examination with the Doppler device to take
the blood pressure, and the coarctation was not
revealed on the angiograms that were done for reasons
that I can't explain here, but that does occasionally
occur. So that we did not realize that the patient
had in addition to the other thing, coarctation of
the aorta.

Q. Would the coarctation that was
not discovered prior to death have any effect on the
digoxin therapy?

A. I would think perhaps it would
only accentuate the congestive heart failure, but I
don't think it would have any effect on the digoxin
therapy application.

Q. Contrary to what we discussed



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prior, my reading of this chart at page 20 in the final autopsy report, and in page 33 in Dr. Heilbut's death report, indicate that there was no treatment with digoxin and diuretics prior to coming to the Hospital for Sick Children. Although I do note that in the Statement of Prima Facie Facts there was a question about that and I couldn't find it referred to in Dr. Rowe's testimony.

So the indications from the Hospital record are that there was no such treatment prior to arriving at the Hospital and prior to arriving at the Hospital the child had survived for 23 days, but when digoxin was started over the next five days the baby seemed to get much worse and died.

A. Yes.

Q. That still doesn't sway you?

A. Not at all, that is a lethal condition which very, very commonly causes death in infants, and had the child survived longer I am sure we would have repeated the catheterization test and probably recognized the coarctation of the aorta.

Q. Now when this child died, do you remember anyone discussing the possibility of digoxin having any possible effect in causing the death?



BB.9

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A. No.

3

Q. None of the cardiologists even

4

considered it as a possibility?

5

A. No.

6

Q. And they didn't check for it?

7

A. Well, as you know, digoxin

8

levels were not taken, except for the one example,

9

that one sample that we have which was within the

10

normal limits under this situation, and so that we

11

didn't suspect digoxin toxicity during life. And at

12

death we felt that the death was due to the

13

Q. Notwithstanding that, Doctor,

14

there were some indications that this might be digoxin

15

toxicity, but you didn't think there was enough

16

indication to look into it?

17

A. To have a level done.

18

Q. I would like to go to the

Kristin Inwood exhibit, 113.

19

THE COMMISSIONER: Are you referring

20

to the Hastreiter again?

21

MR. LABOW: No, I don't.

22

THE COMMISSIONER: I will give it back

to Mr. Tobias.

23

MR. TOBIAS: Thank you.

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BB.10

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MR. LABOW: Q Kristin Inwood was a child from the Toronto East General who came to the Hospital for Sick Children on March the 5th for an echocardiogram and then returned to the Toronto East General, and was admitted to the Hospital on the 16th of March. Now in Volume 18, page 3087, Dr. Rowe points out that this child was on digoxin since the 28th of February.

Now, when this child entered the Hospital she was continued on digoxin and diuretic treatment, and a catheter was scheduled for the 13th of March. And at page 75 there is an order for digoxin levels once a week, actually that is on page 76.

A. Yes.

Q Was that a routine order?

A. No, it is necessary for the doctor to order that specifically.

Q Did you have any idea why it was ordered on a weekly basis?

A. I guess that particular physician wanted to see what the dig. level was each week.

Q Is there any indication to you in your review of this why that would be so?

A. This may be the doctor's policy to always do that.



BB.11

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Q. But it is not a policy that you employed, and it is not a specific policy of the Hospital?

A. No. There is a tendency in people with chronic heart failure to perhaps assess the digoxin level once a week, but this is not a routine that has to be done each time, and it is a matter of the physician deciding whether he wants to do that or not, and he has ordered that once a week this child have a digoxin level done and he is an infant that is quite ill and I think that is a reasonable thing to do.

Q. Now on page 64 there is a consultation?

A. Yes.

Q. Did you do that consultation, Doctor?

A. Yes, that is my signature at the bottom.

Q. And your second order at the bottom is to continue low doses of digoxin, is that what that says?

A. Yes, I think so:

"Continue low dose of digoxin and diuretics."



BB.12

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Q. Now, page 66 of the Statement of Prima Facie Facts points out that because the EKG showed signs of digoxin toxicity, the order for digoxin was cancelled. And at page 75 there is an order of Dr. Kantak holding the digoxin and asking for a level to be done, this is on the 12th of March.

A. Yes.

Q. Now we know from Dr. Rowe's testimony that this was apparently ordered because this baby mistakenly received a dose of digoxin meant for another baby. In Dr. Bain's report on page 20 he says:

"This child received an excessively large dose of digoxin through error."

A. Not an excessively large ---

Q. Well excessively large for this baby?

A. Yes. Do you happen to know what the amount was that was given?

Q. No, I don't, but those are Dr. Bain's words.

THE COMMISSIONER: There is an incident report, isn't there?

MR. LABOW: Yes, it is Exhibit 113A.

THE COMMISSIONER: 113A?



BB.13

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MR. LABOW: Exhibit 113A. The
incident reports says ---

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THE COMMISSIONER: I have got it here,
all right, it is right here.

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MR. LABOW: It doesn't seem to tell us
what the dose was.

8

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Q. This was on the 12th of March
and a level is taken which eventually comes back at
2.6?

10

11

A. Yes.

12

13

Q. Now on the 13th, the child
becomes tachycardic, and then at about 2:30 in the
morning, bradycardic, and at 3 o'clock is pronounced
dead.

14

15

16

Now, this child was only in the
Hospital from the afternoon of the 11th until the very
early morning of the 13th.

17

18

A. Yes.

19

20

Q. And was mistakenly given a
dose of digoxin. Do you recall examining this child
after death?

21

22

A. I am concerned about this
incident report, and I can't see any evidence of what
amount of digoxin was actually administered in error.

23

24

Q. Well, Doctor, notwithstanding
that, we don't know the amount.

25



BB.14

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A. Yes.

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Q. If the EKG upon admission

4

exhibited some signs of digoxin toxicity and digoxin

5

was ordered held, and then by mistake digoxin was

6

administered to this child, which is apparently what

7

happened in that sequence?

8

A. Yes.

9

Q. Would you not think that the

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doctors might consider digoxin toxicity as a cause of
death?

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CC/BB/ak

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A. I think that it is more reasonable to suggest that this is involved in the death of this child than on the previous one.

Q. Well, that's not my question. Did you consider digoxin toxicity in this case as a possible cause of death?

A. This should be certainly considered if I didn't. I haven't got a note on the chart however.

Q. Well, there don't seem to be any notes on the chart bringing up that possibility.

A. No. But of course he was in the Hospital such a short time.

Q. But it is still the duty of the Hospital I suppose, and correct me if I'm wrong, if a child dies there to try and determine what the cause of death was.

A. Yes, of course.

Q. Do you remember considering digoxin toxicity as a cause of death in this matter?

A. I don't think so.

Q. Reviewing the situation that I have given you, do you consider it a possibility?

A. Yes, I think this is a possibility. However, I think this child had a



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post mortem - yes, he did have. Yes, I think that this is a possibility in this child but the child also, as you know, has other very serious problems that would certainly be related to his death as well.

Q. Fine. The next child I would like to consider is Barbara Gionas. It is Exhibit 105.

Now, Barbara Gionas was transferred from the Toronto General Hospital the day after she was born and remained in the Hospital for Sick Children for approximately six weeks.

A. Yes.

Q. Now, she came into the Hospital on the 23rd of January, was seen by a cardiologist, which I assume was not yourself, you were not the ward chief in January, is that correct?

A. No. She came into the new born ward called 7G.

Q. Correct. She was started on digoxin at the time and for some reason, although she was started on digoxin on the 23rd of January, there was no digoxin level checked in the chart until the 3rd of February, although, we have determined that there was a level in Dr. Ellis' digoxin book for the 30th of January, if I'm not mistaken.

A. Yes.



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Q. Now, would you have considered it advisable to check the digoxin level before that?

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Q. So, you don't think that it would have been advisable to do it prior to that?

11

12

A. If there was no indication that it might be elevated.

13

14

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Q. Well, Dr. Rowe said at page 3149 that he thought it would have been advisable and prudent to take a level earlier than that.

16

17

A. Yes.

18

19

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Q. You still wouldn't have unless you had seen some signs of toxicity?

23

24

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A. Yes. I think it might be prudent to do it but perhaps, particularly with all these periods I have had in the last few months, but I think at that time I think that I might not have.

Q. Well, when we were discussing the Pacsai child with you.



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A. Yes.

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Q. In your evidence at Volume 32,

4

page 6127, when you were asked what prompted

5

Dr. Costigan to order a sample at that time you said

6

that he was a good clinician and should cover all

7

the bases.

8

A. Yes.

9

Q. But you still would have not

10

ordered a level for that length of time unless you

felt you had a reason to?

11

A. Yes, that's right. Perhaps I'm

12

not as good a clinician as Dr. Costigan.

13

Q. I'm not suggesting that at all.

14

Now, this child underwent surgery twice

15

and in mid-February, on the 16th, Dr. Contreras, at

16

page 51 decides to check the digoxin level because of

an abnormal ECG.

17

A. Yes.

18

Q. Now, the level, the previous

19

level was 2.3?

20

A. Yes.

21

Q. On the 5th?

22

A. Yes.

23

Q. Of February?

24

A. Yes.

25



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Q. And the next level was 1.4.

3

A. Yes.

4

Q. Now, notwithstanding the low

5

numbers, if you had seen clinical symptoms would the

6

ordering of a level be the proper thing to do?

7

A. Yes, or, particularly if the

8

electrocardiogram showed typical signs of digoxin

9

toxicity, and I am still looking for a copy of the...

10

Q. Page 51.

11

A. Is it page 51?

12

Q. Page 51.

13

A. No, I know, but I want to

14

see the actual electrocardiogram. Have you encountered
that?

15

Q. No, I haven't.

16

A. In review of this chart.

17

Q. I have not. I don't know

if anyone else has.

18

A. Because I don't see it. I

19

would be happier if I was able to see the chasing

20

but I can't see this, I'm sorry.

21

Q. Now, Doctor, in this child the

22

digoxin was then put on hold, the level went down to

23

1.4?

24

A. Yes.

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Q. As of the 17th of February.

digoxin was started again and as of the 24th of
February was back up to 2.1?

A. Yes.

Q. So, this level went from
2.3 to 1.4?

A. Yes.

Q. To 2.1?

A. Yes.

Q. Would that be a concern that
the level was fluctuating?

A. It would suggest that and
one would be a bit concerned about the possibility
of some renal problems and we would have to look into
that.

Q. Now, this child was transferred
to Ward 4A on the 26th of February.

A. Yes.

Q. And you became the ward chief
in March?

A. Yes.

Q. Now, when you become the
ward chief and there is a child on the ward that had
been there, such as this one.

A. Yes.



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Q. What do you review as ward chief?

4

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A. I review the patient's chart and the patient himself and review the orders and be sure that they seem to be consistent and change them if I think there should be some variation in them.

9

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Q. So, you would have reviewed this chart.

Now, at the end of February once on the ward, on the 26th the child was vomiting and irritable; on the 28th was still vomiting, restless and agitated; on March 1st continued to be irritable; on March 2nd, continued to be irritable and had shallow and irregular respirations, continued to vomit; and on March 3rd on page 69 there is apparently an order from Dr. Runge.

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THE COMMISSIONER: That's the right page, is it?

MR. LABOW: Q. I'm sorry, I think it is page 189. Yes, it is page 189 which seems to indicate that the digoxin doses were lowered. Is that what an arrow going down means, the top order on page 189?

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A. Top order on 189. 189,



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oh, I'm sorry. Yes, that he has lowered the maintenance dose slightly.

Q. Now, do you have any idea personally why that was done?

A. I'm not sure. He may have been wondering about digoxin toxicity.

Q. Do you have any actual recollection?

A. No, I don't have a recollection of that.

Q. All right. To continue on with that month. The baby continues on digoxin, is relatively stable and then on the 7th of March there is a note on page 73 that although the last digoxin level was 1.9 on the 3rd of March the baby had vomited and the plan was to hold digoxin.

A. I'm sorry, what page of the chart?

Q. 73.

A. 73, all right.

Q. And the impression on the bottom of that page says:

"(1) Digoxin toxicity".

The doctor's order of that date found at page 190 is "hold next dose of digoxin" and "digoxin level



Monday morning".

A. And he also ordered that digoxin be held for 48 hours I believe.

Q. Correct.

A. In his note of the 7th.

Q. That's right, the next day - the next note. He asks for a 'digoxin level now please'.

Now, Dr. Rowe indicated at page 3151 that it was his impression that this doctor was investigating the vomiting and arrhythmias that Baby Gionas was exhibiting. Do you have any recollection of that?

A. I think it would be reasonable to think that that would be the reason that he made those orders.

Q. Do you have any recollection of it as ward chief?

A. No.

Q. If a doctor, when you were ward chief, if one of these doctors suggested or thought that there might be digoxin toxicity in a child, would they bring that to you?

A. They might or they might not.

Q. They wouldn't bring it to you as a matter of course?



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CC10

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A. Not as a matter of course because there is an obvious set of things that we do in such a patient.

Q. Fine. Now, the digoxin level reported, and it is reported at page 238 is 1.2.

A. What was the page number again?

Q. 238.

A. 238, okay.

Q. On page 239 there is a chemistry report dated the 9th of March at 3:30 pointing out that the digoxin reading will follow. And then the next report on the 10th of March points out that the level was 1.2. Notwithstanding that, this baby died on the 9th early in the morning.

A. Well, I am a little bit confused here. On the 7th of March there was a digoxin level of 1.2.

Q. That's correct.

A. On 238. Is there a subsequent digoxin level?

Q. No, no.

A. Available on him?

Q. No, the one on the 7th of March wasn't report apparently until the 10th of



1
2 March. That's the level that this doctor was
3 investigating.

4 A. But it is 1.2.

5 Q. That's right.

6 A. I don't quite understand the
7 sequence here because you have a digoxin level of
8 1.2 and then you have some levels of chemistries
9 on the 8th and 9th of March. I don't understand if
10 he had a digoxin level of 1.2 that he would be worried
about digoxin toxicity.

11 Q. Well, in this case it appears
12 to me that the doctor was worried on the 7th,
13 ordered the level, the level was apparently 1.2 but
14 the level was not conveyed up to the floor until the
15 10th.

16 A. Oh, I see.

17 Q. Now, does the fact that this
18 baby's digoxin level was only 1.2 preclude the
19 possibility that this baby died from digoxin
toxicity?

20 A. If the digoxin level was 1.2
21 just prior to the death, then I think that does.

22 Q. Two days prior?

23 A. Yes. Well, you see, I don't
24 know. It may be that it went up dramatically in the
25



CC12

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next two days but if it was 1.2 shortly before death
then that precludes the possibility of digoxin.

3

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Q. So, it is impossible that a

5

child could die from digoxin intoxication with a

6

level of 1.2?

7

A. At the time of death, yes.

8

Q. Absolutely impossible?

9

A. I think it is, yes.

10

Q. Now, this level was taken on

11

the 7th when a doctor had some kind of suspicion that
it might be digoxin toxicity.

12

A. Yes.

13

Q. And then child became restless

14

and hard to settle and bradycardic on the 8th.

15

A. Yes.

16

Q. And died.

17

A. Yes.

18

Q. Was there any discussion about

19

the possibility of digoxin toxicity being the cause
of death?

20

A. Yes, I'm sure there wouldn't

21

have been. There would have been lots of discussion

22

about him when his death was reported to our group

23

but I think that we wouldn't have discussed it as

24

a possibility that he might have digoxin toxicity.

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CC13

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Q. Now, when would you have
discussed this case?

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A. I'm not sure what day he died.

5

6

Q. He died on the 9th at 1 o'clock
in the morning.

7

8

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A. What day was it? I mean, if
that happened to be on the weekend he would be
discussed on the next Monday. If it happened to be
in the middle of the night ---

10

11

THE COMMISSIONER: The 9th would be
a Monday because the 21st was a Saturday.

12

THE WITNESS: Oh, yes, yes.

13

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THE COMMISSIONER: So, the 7th is
a Saturday.

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THE WITNESS: That's right. So,
it would be the next Monday and we would presumably
discuss this case as well as -- Of course, yes,
that's true, we would have discussed it on our
Monday conference.

19

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THE COMMISSIONER: She died at -
what hour?

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THE WITNESS: Early in the morning.
I think I have that. Yes, she died at 1:45 a.m. of
the 9th. So, at 8:30 in the morning of that day, if
it was a weekday we would have discussed her case.



CC14

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MR. LABOW: Q. So, the fact that this child had suspected, or one of the doctors suspected that this child was toxic?

5

A. Yes.

6

Q. The fact that the level was only 1.2 would preclude any discussion about digoxin toxicity being a cause of death two days later.

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A. I think so, yes. Now, we are making an assumption that there wasn't anything dramatic that happened between the dig. level two days before and the time - to suggest that she might have been a tremendous increase in the dig. level and for instance if her kidneys stopped working altogether two days before, I suppose then we might think about that. But I think that there wouldn't be a discussion about the possibility of dig. toxicity in this case.

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Q. Well, the symptoms were, the night prior, that her apex was irregular.

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Q. She was restless and hard to settle?

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A. Yes.



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Q. Her apex fell; she became
bradycardic and then there was a Code 23 called, a
Code 25 and she died.

A. Yes.

Q. Are those symptoms con-
sistent with digoxin intoxication?

A. Well, we have been through
this a hundred times in the past.

They could be consistent with it,
but it isn't, in this particular case, anything
that one would consider seriously.

Q. Well, she also had sinus
arrest and junctional rhythm.

A. Yes.

Q. Are those consistent?

A. Yes. That can occur.

Q. But notwithstanding there
was a suspicion previously --

A. Yes.

Q. -- no level was ordered --

A. Yes.

Q. -- you don't consider this
to be a possible cause of death?

A. I think it very unlikely.
I think that she is a child who had two operations



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and, as you know, she had coarctation repair and then a second operation of pulmonary banding, and a most unusual infundibular narrowing at the base of the artery to the lungs, and she also has this banding of the pulmonary artery, and I think that the assumption of the clinicians, me included, felt that this was the explanation for her death.

Q. So this was not suspicious enough for you --

A. No.

Q. -- to look into it any further?

A. No.

Q. Doctor, are digoxin levels now taken as a matter of course?

A. No. I have been very careful to insist that if digoxin levels are taken, they must be ordered by a doctor, and I have instructed all the Fellows to be sure that they are responsible to order digoxin when they feel it is indicated.

Q. So in this kind of a situation they still would not have ordered a digoxin level to find out what the level was at death?

A. At death?

Q. At death.



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A. Well, if this patient had
died on our ward, we are obliged to do digoxin level --

Q. Now?

A. -- before we do anything.
Now, yes.

MR. LABOW: I have no further
questions.

THE COMMISSIONER: Thank you, Mr.
Labow.

I think, Mr. Shanahan, that you
declined before or not?

MR. SHANAHAN: Your Honour, I just
have one or two questions. Could I put them after
the break?

THE COMMISSIONER: Yes. But you
have one or two questions, and let me see, Miss
Thomson, have you any re-examination?

MS. THOMSON: I believe Mr. Scott
will be about ten or fifteen minutes in re-examination.

THE COMMISSIONER: He is around
somewhere, is he?

MS. THOMSON: Yes.

THE COMMISSIONER: Ms. Chown?

MS. CHOWN: I should be about five
minutes.



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THE COMMISSIONER: I have now forgotten which of you two distinguished counsel started this business.

Mr. Lamek?

MR. LAMEK: We will finish this afternoon.

THE COMMISSIONER: All right. We'll take a few minutes.

--- recess.

--- on resuming.

THE COMMISSIONER: Yes, Mr. Shanahan.

CROSS-EXAMINATION BY MR. SHANAHAN:

Q. Dr. Fowler, I act on behalf of the families of the Lombardo and Dawson infants, and I don't think as I looked over their medical notes that, in fairness, you really had any direct or perhaps even any contact at all with those children.

A. Yes. No, I don't know them in detail at all.

Q. All right, sir.

But, sir, one aspect of your evidence that has come up that you have given with respect to the timing of certain events that occurred late in March, the tying in to the police investigation, that does cause me some concern and I just have



1
DD5 2 a question or two about that.

3 As I see it, sir, Kevin Pacsai
4 dies on March 12th; is that correct?

5 A. I can't remember but I
6 agree - I will go along with that.

7 Q. You don't immediately know
8 of his digoxin readings. I don't think by my
9 again recollection of the evidence, you don't know
10 his dig. readings until March 18th?

11 A. This is, I understand, the
12 day that we received them.

13 Q. And the meetings with the
14 police, sir, are on March 21st, Saturday, March 21st?

15 A. Yes, in the Coroner's office.

16 Q. All right. And of course the
17 death of Allana Miller, or at least the readings on
18 Allana Miller you get are after that meeting?

19 A. Yes.

20 Q. Sometime later on the 21st?

21 A. Yes.

22 Q. All right.

23 I think you put to Mr. Lamek at
24 some point in time and I am going to read it to you here,
25 just to be fair to you, I think you made clear to
Mr. Lamek that it wasn't until you -- after the



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police meetings and when you got the results from Allana Miller that you really start to suspect in your mind or entertain considerations in your mind that there may have been some intentional overdose of digoxin?

A. Yes.

Q. All right.

Looking at the transcript of these hearings for September 13th, Volume 32, and you are being cross-examined in chief by Mr. Lamek and the passage I am reading from is page 6147.

THE COMMISSIONER: You are absolutely right I want to tell you. But it is technically known as an examination in chief.

MR. LAMEK: We get through faster that way.

THE COMMISSIONER: What page was it?

MR. SHANAHAN: It was page 6146, sir, and the volume again was 32, and the question starts at line 14, sir.

Q. The question put to you was:

"Q. And was it from March 20th that you began seriously to entertain a thought that this may have been an intentionally



1 administered overdose?"

2 And your answer, sir, was:

3 "A. Yes, I think that is a
4 possibility. I still, as you can
5 well imagine, physicians sort of
6 feel that all other types of
7 explanations are more palatable than
8 that one and so I felt that it
9 still was possible that there was
10 some type of error. I think
11 probably on Saturday with - at the
12 meeting, it became clearer that when
13 these two patients were discussed
14 together it became much clearer in
15 my mind, and I think probably not
16 until Saturday afternoon did I feel
17 that really this was very sinister
18 what was going on in the Hospital."

17 And Mr. Lamek says:

18 "Q. Doctor, I can understand a
19 physician would find it repellent
20 even to contemplate that someone in
21 hospital might be deliberately
22 damaging patients."

22 And your answer is, "Yes".

23 "Q. But, if by the 20th you were
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beginning to be forced to face that possibility, did you not at that time cast your mind back to the Estrella result that you had learned of perhaps a week earlier?"
"A. No, I didn't on the 20th because that had been satisfactorily, in my mind, discarded as not a true bill. So I didn't on the 20th think of anything except that one case of Pacsai."

I think in fairness your position here as I examine you today is that you still abide by that?

A. In terms of the timetable recognition of the possibility of an intentional type of overdose.

Q. Right, sir.

And yet again, sir, I think there is some evidence of yours that you indicate that after you get the reading on Pacsai on the 18th --

A. Yes.

Q. -- and before the meeting with the police on the 21st, and before the death of Allana Miller --



1
DD9 2 Q. -- the results on Allana
3 Miller, that in fact you return yourself to the
4 ward and you speak to people there and you check
5 dosages and supplies and who administered what.

6 A. Yes.

7 Q. Is that correct?

8 A. That was under the direction
9 of Dr. Carver who wanted me to do that, but that of
10 course was the reasonable thing to do under the
11 circumstances.

12 Q. All right. And to be clear,
13 sir, the timing of that is after you get the Pacsai
14 readings on the 18th?

15 A. Yes.

16 Q. And before the meeting with
17 the police on the 21st?

18 A. Yes, that is true. The
19 Pacsai readings were the event that caused us to
20 explore the possibility of errors on the ward.

21 Q. I put to you then, sir,
22 in fact you went back to the ward on that occasion and
23 spoke to a nurse or nurses then, and in fact actually
24 put to them the proposition as to whether they knew
25 if there was anyone there at the time who they felt
was unbalanced enough to perhaps administer a



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deliberate overdose of digoxin?

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A. No, no, that is entirely

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out of context.

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I suppose you are reading me

6

some from the preliminary hearing. I went back to

7

the ward and made investigations in terms of who

8

gave the dig. and who signed it off and this sort of

9

thing, and that little comment about whether there

10

was anybody so imbalanced was made in jest, not to

11

the head nurse but there must have been somebody

12

else around and that was not at the same time in my

recollection at all.

13

I was not saying that in a serious

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way at all, and we didn't have a discussion about

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that possibility at all, and that was something that

16

at that particular time I felt was a joke. I realize

17

at this time and in this place it sounds callous,

18

but I am afraid that wasn't -- that was a casual

comment and wasn't a part of my conversations with

19

the head nurse that I remember.

20

Q. Let's be clear then. You

21

are agreeing you went back to the ward and you did

speak to a nurse or nurses?

22

A. Yes, the head nurse.

23

Q. You did speak to them between

24

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the 18th and the 21st after Pacsai's reading?

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A. Yes.

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Q. And before the police meeting?

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A. Yes.

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Q. That you did do some checking
about digoxin?

7

A. Yes.

8

Q. And its administration?

9

A. Yes.

10

Q. And that you did put two a

11

nurse, specifically a Mrs. Crosswell, who was a

12

teaching team leader on 4A and 4B, as to whether she

13

knew anyone who would be unbalanced enough to administer
digoxin?

14

A. Yes. No, that was -- I

15

don't think that was at the same time I was exploring

16

the whole problem of the digoxin, and that was not

17

meant as a serious question.

18

Q. All right.

19

Quite apart from when you were

20

exploring digoxin, at the time you would be checking

21

to see which nurses would be looking after Pacsai --

22

A. Yes.

23

Q. -- that you said to Mrs.

24

Crossman or asked her whether she thought there was

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DD12 2 anybody unbalanced enough that might have administered
3 an overdose?

4 A. No, I do not think that was
5 at the same time. I think that was another occasion
6 on the ward.

7 Q. Let me put to you, if I
8 might, sir -- there was evidence given at the
9 preliminary hearing with respect to Susan Nelles,
10 in Volume 21 of the evidence, given at that hearing,
11 on page 15, sir. Mrs. Crosswell is being cross-
12 examined by Mr. Cooper.

13 Perhaps I will commence, Mr.
14 Commissioner, on page 14.

15 The first question is, sir:

16 "Q. Well, I take it from your
17 answers to Mr. McGee's questions,
18 Mrs. Crosswell, that you haven't
19 seen Susan Nelles in or near the
20 Hospital since her arrest?"

21 "A. That is correct."

22 "Q. That is correct. All right.
23 Now, Mr. McGee asked you about
24 Dr. Fowler and his discussions, or
25 you gave evidence about Dr. Fowler's
discussion with you after the death



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of Kevin Pacsai, isn't that right?"

"A. That is right."

"Q. And didn't he or perhaps you testified to this, did he say to you that Pacsai, they had found that Pacsai had a very high digoxin level post mortem?"

"A. Yes. He mentioned that there was a high digoxin level post mortem."

"Q. And he wanted you, you said I think, to find out which nurses had looked after Pacsai?"

"A. That is correct."

"Q. And didn't he also say to you, didn't he also ask you at that time, Dr. Fowler that is, did he not ask you at the same time if you knew of a nurse who might have been unbalanced? Didn't he ask you that?"

And her answer:

"Yes, he did."

A. Is that the same time?

Q. If I can just finish this

here:

"Q. And you told him you weren't



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aware of any nurse that might have
been unbalanced?"

"A. That's correct."

"Q. In other words he was saying
or he was implying that somebody
had given Pacsai a huge dose of
digoxin and it is likely that the
person isn't quite right mentally?
Right? Isn't that the implication?
Unbalanced?"

"A. Yes."

"Q. Yes."

"A. That's the implication."

Now you have indicated that you
went back to the floor and did your own investigation,
if you like, after the 18th and before the 21st, and
I am suggesting to you that that conversation there
took place in that time period between the 18th and
the 21st.

A. That is not my recollection
of that, the timing. I realize that I have said that
but I didn't think that that was part of that conversa-
tion. I talked to -- and I don't think it was Diane
Crossman who was a team leader. I think it was
Liz Radojewski who did all the -- doing all the



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checking with her as I remember it.

Now it may have been Diane Crossman, but I felt that I went over that, the details of who took, who gave the dig. and who checked it out, and that sort of thing, and my understanding of that was at a different time in that period.

I will admit that. It was in that period, but that was a casual remark and I was not seriously thinking of that at all.

Q. Well, apart from who you said it to, are you saying you made that comment in jest?

A. Yes.

Q. And that you made it after the 21st?

A. After the 21st?

Q. After the meeting. When are you saying the timing of that comment is, do you know?

A. I think that that comment was at some time but not at the same time I was investigating the dig. administration on the ward, and prior to the meeting with the Coroners.

Q. So, if it was not made when you were doing your general digoxin investigation, it was done before the meeting of the 21st?

A. Well, it is a casual remark



1
DD16 2 and I think that it probably was at that time but I
3 am not sure.

4 Q. And you think it was a
5 casual remark made in jest?

6 A. Yes.

7 Q. Sir, I suggest to you that
8 the bottom line here is even before the meeting on
9 the 21st and before the readings on Miller that in
10 fact you had suspicions yourself and that you were
11 going to the floor to see if you could find from the
12 other nurses who might be unbalanced enough to have
13 administered this drug overdose?

14 A. Yes. And I would say that
15 I wouldn't agree with that.

16 MR. SHANAHAN: All right. Thank you,
17 sir.

18 THE COMMISSIONER: Yes. Thank you,
19 Mr. Shanahan.

20 Mr. Scott?

21 RE-EXAMINATION BY MR. SCOTT:

22 Q. Well, doctor, the chance
23 that I get to examine you shows that you are very near
24 the end of this exercise.

25 I want to deal, first of all, with
the matter that my friend just raised with you. You



1
DD17 2 told us that you were asked I think by Dr. Carver follow-
3 ing when the Pacsai readings came back to make an
4 investigation?

5 A. That is correct.

6 Q. Yes. And I think there is -
7 I may have missed this, Mr. Commissioner - I think
8 there is before you a written memorandum of the
9 investigation that you made to Dr. Carver?

10 A. Yes.

11 THE COMMISSIONER: What is the
12 number of that?

13 MS. KITELY: 164.

14 MR. SCOTT: 164.

15 Q. Now I don't need to take you
16 through that in any detail, but I take it that was
17 made before -- I'm sorry, that was made after the
18 Pacsai readings were received?

19 A. Correct. That was the --

20 THE COMMISSIONER: Sorry?

21 MS. CRONK: 110.

22 THE COMMISSIONER: 110.

23 THE WITNESS: That was the reason
24 I was asked to do that investigation because the
25 Pacsai readings were available.

MR. SCOTT: Q. And in that report -



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I don't want to take you through it all again, but
you told us that you spoke to Nurse Radojewski?

A. Yes.

Q. You asked her to interview
some other nurses?

A. Yes.

Q. That you asked her to make
enquiries about the volumes of elixir on the floor?

A. Yes.

Q. And the consumption rate at
weekly intervals?

A. Yes.

Q. That you sent some of the
elixir to the laboratory, to Biochemistry to be
rated as to concentration?

A. Yes.

Q. And that you did a number of
things including reviewing the chart and so on?

A. Yes.

Q. Now the exhibit shows that
it was received in Dr. Carver's office on March 23,
1981. Well maybe it doesn't. Maybe just the one I
have does. We will be dealing with Dr. Carver next
week, but I want to show you what appears to be a copy
of your memorandum which is already an exhibit.



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DD12 THE COMMISSIONER: I think what is
3 almost more important, though, is at the bottom
4 just beside Dr. Fowler's signature is March 20, 1981.
5 MR. SCOTT: Yes. All right. That
6 is even better. It is cut off on mine.
7 Q. Is it fair to say that this
8 memo would have been dictated on or about March 20th?
9 A. Yes.
10 Q. And do I take it it would
11 have been dictated shortly after your investigation
12 was completed?
13 A. Yes.
14 Q. And then delivered the next
15 day to apparently or within a day or two to Dr.
16 Carver?
17 A. Yes.
18 Q. Can you tell us then how
19 long the investigation would have taken?
20 A. I really can't remember.
21 I am sure that it might have included -- it may have
22 taken a day.
23 Q. Well, if you received the
24 serum levels on the 18th --
25 A. Yes.
Q. -- I take it would have taken
two days?
A. Yes, I presume.



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Q. And the Saturday meeting is
the 21st?

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A. Yes.

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Q. Now my friend read to you
Mrs. Crosswell's examination at the preliminary
inquiry. I take it is clear, and perhaps obvious
that you would not have discussed Pacsai and Pacsai's
serum levels with her until after those serum levels
were obtained?

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A. No, right.

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Q. So are you clear that the
conversation, whether it was suggested or not,
occurred after those serum levels were obtained?

14

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Q. Now at page No. 7 of that
examination Mrs. Crosswell says this.

16

17

THE COMMISSIONER: Is it Crosswell or
Crossman?

18

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MR. SCOTT: It is Crosswell in the
transcript.

20

THE WITNESS: It is Crosswell.

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THE COMMISSIONER: Somewhere I got
Crossman. Well, it doesn't matter I think we are
all agreed it is Crosswell.

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MR. OLAH: Mr. Commissioner, Exhibit



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110 it is referred to as Crossman, on the second page.

THE COMMISSIONER: That may be where I got it, at any rate you have repented have you, Dr. Fowler and it is now Crosswell.

THE WITNESS: Yes.

Q. And she says there, and I will just read it to you, Question 20:

"Did you become aware of the high digoxin level in Kevin Pacsai's blood?

A. Yes, it was Dr. Fowler who spoke to me on the ward and mentioned that the digoxin level was quite high in Kevin Pacsai, and he did mention the amount and he asked me to try to find out what nurses had been looking after Kevin Pacsai so that they could write down a statement."

Now, stopping right there. Did you ask any nurses to write down a statement in the investigation that took place before the Saturday meeting?

A. No, I didn't personally have that done, I expected to have the nurses responsible



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would do that.

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Q. The point I am asking you,

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the point I am trying to emphasize.

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MR. LAMEK: Could he finish his

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answer.

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I wanted you to be able to finish your

8

answer.

9

THE WITNESS: I am sorry, I don't

10

remember.

11

Q. The point I am emphasizing is

12

in your memo of the 20th you say that you asked

13

Liz Radojewski to interview certain other nurses,
and ask certain other nurses questions?

14

A. Yes.

15

Q. What I am asking you now is

16

did you yourself, or did anybody at your direct

17

request the nurses to write down statements during
the course of the investigation about Pacsai?

18

A. I don't remember doing that

19

at all.

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Q. At a later stage after the

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Monday March 23rd, when the police came in, there
was a good deal of writing down of statements?

22

A. Yes.

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Q. All right. Now, back to Mrs.

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Crosswell she says:

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"Yes, it was Dr. Fowler who spoke

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to me on the ward and mentioned that

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the digoxin level was quite high in

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Kevin Pacsai, and he did mention the

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amount and he asked me to try to find

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out what nurses had been looking after

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Kevin Pacsai so that they could write

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down a statement.

11

Q. I see. How long after, do you
recall when that was when he told you
this?

12

A. I know that it was within a
week.

13

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Q. Within a week of the baby's
death?

15

16

A. That is correct."

17

Q. Now stopping there, were any

18

statements taken as far as you know before March the
23rd?

19

A. No.

20

Q. Does that help you to place in
any way when you may have had a conversation with
Miss Crosswell?

21

22

23

A. Well it is conceivable that

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25



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2 it was the following week, but I never asked a nurse
3 to take some statements. My investigation involved
4 looking at the order sheet and seeing who had signed
5 it and asking Ms. Radojewski to actually interview
6 those nurses and be sure that she did sign them and
7 that this was the appropriate dose. I don't ever
8 remember anybody asking - I never remember asking
her to have statements taken from nurses.

9 Q. I am just going to ask you
10 about one article and it happens to be the article
11 that you wrote?

12 A. Yes.

13 Q. Which is Exhibit No. 175:

14 "Sudden unexpected deaths in children
with congenital heart disease."

15 And as I read this article it deals with ambulatory
16 patients over a year old, am I right about that?

17 A. That's correct.

18 Q. And am I correct that that
19 is what it deals with exclusively?

20 A. That is correct.

21 THE COMMISSIONER: And am I correct that
that is what it deals with exclusively?

22 THE WITNESS: That is correct.

23 THE COMMISSIONER: Do they have to be
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ambulatory?

MR. SCOTT: Well, or crawling.

THE WITNESS: Yes.

THE COMMISSIONER: I guess everybody
crawls by the time they are one year old.

THE WITNESS: They have to be out
of hospital and they have to be ---

THE COMMISSIONER: Well they are out
of hospital after seven days.

THE WITNESS: Yes, but they might be
in the hospital - you see all these people had
heart disease.

THE COMMISSIONER: Yes.

THE WITNESS: And they might have been
back in hospital for some reason but they have to
be out of the hospital to fulfill my definition of
sudden death, and they have to be at least one year
old when that occurs, and many of them are much older
than that that was studied.

This paper is an entirely, a
descriptive paper, that outlines which types of
heart disease in children causes sudden death when
they are beyond a year of age. I just listed them
and said there was so many of this type, and so many
of that type and I wasn't attempting to do any type



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of statistical examination. It was just a
description of the sort of abnormalities that cause
sudden death in our population.

4

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Q. Does this paper tell us anything
at all about the sudden death in non-ambulatory
patients under one year old?

6

7

A. No, it does not.

8

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Q. Oh, just while we are at it,
can you tell me, and I asked Dr. Freedom the same
question. Can you tell me from your own clinical
experience the highest kinds of digoxin readings
that you have seen in living patients?

13

14

15

A. I would think that this was -
and I can't remember the specific patient, but I
think I could honestly say that it would never be
in excess of 8 or 9 nanograms.

16

17

18

Q. Have you in fact seen 8 or 9?

A. Yes, I think it is conceivable
that I have seen that in somebody that has survived.

19

20

Q. And I take it that you have
seen fours, fives, sixes and sevens?

21

22

23

24

25

A. Oh yes.

Q. With some frequency?

A. Yes.

Q. And have you read the literature



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that describes digoxin readings in living patients that are to some degree in excess of 8 or 9, 12, 14 and 15?

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A. Yes. The only examples that I can think of at all are special pharmacological studies in which they give a dose of digoxin and then take blood samples every minute or two to see the curve, and sometimes they will go up as high as 9 or 10, I would think not above 10.

10

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Q. Yes.
A. But that is a special experimental situation. In an ordinary patient 8 or 9 would certainly be the top.

14

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Q. All right. But you have seen 8 or 9 yourself in non-experimental circumstances?

20

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A. Yes, I think that is true.

Q. And would that be a common, I shouldn't say a common experience, would that be an experience in your opinion shared by other cardiologists of equivalent experience?

A. Yes I think that may be true.

Q. Now, let me come to the Allana Miller business. Mr. Hunter and I had an exchange when we were cross-examining Dr. Rowe, and I won't take you all through it again, but I want to



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clear it up.

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5

First of all, are you aware, dealing with Allana Miller; I will put it this way. First of all, do you know Dr. Nadas of the Boston Children's Hospital?

6

A. Yes, I do.

7

8

Q. Is he a well respected cardiologist?

9

A. Yes.

10

11

12

Q. Were you aware that in examination of the death of Allana Miller he rated her death cardiologically as consistent with the clinical diagnostic concerns?

13

A. Yes.

14

15

Q. What is your own view on that subject?

16

A. Yes.

17

Q. Leaving aside any serum levels.

18

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A. Yes. No, that would be my view of that, and that of course I felt knowing the patient and realizing how sick she was, and as I have mentioned before she is so sick that she was brought in the hospital and we were hoping to do the operation sooner than scheduled because she was so ill with failure, so that I am not surprised that she



1

2

did die because of her disease.

3

Q. Now after she died, and before

4

any serum levels, do you recall, you may not recall

5

the name, but do you recall having a conversation with

6

a fellow, or a resident, about whether this should be

7

a coroner's case?

8

A. Yes. I was phoned at home

9

at the time of her death and he notified me.

10

Q. Do you know who it was?

11

A. I think it would be probably,

it probably would have been Dr. Schaffer.

12

Q. I was going to suggest Dr.

Schaffer's name.

13

A. Yes.

14

Q. Regardless of the doctor do

15

you recall the conversation?

16

A. Yes I remember the - I don't

17

remember the exact words of that conversation, but

18

I obviously told him that this was not a case for

19

the coroner and I was, I checked into the chart, and

20

it also showed that he had ticked off "coroner not

to be notified".

21

Q. Did you yourself, did you

22

observe any disagreement between you and him on that

23

matter in that telephone conversation?

24

25



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A. No.

3

Q. And looking at the matter now,

4

and leaving aside the serum level, do you see any-

5

thing in the record, or clinical circumstances of

6

Allana Miller that suggest it to be a case for the
coroner?

7

A. No.

8

Q. Therefore, when you went to

9

the meeting at the coroner's office on Saturday,

10

leave Dr. Rowe aside for the moment, did you have

11

any concern about the Miller death as being a death
like Pacsai or Estrella?

12

A. No, I did not.

13

Q. I take it it was not until

14

serum level was returned, the post mortem serum level

15

was returned that evening at 8 o'clock that your

16

concern escalated?

17

A. That's true.

18

Q. Now, let me just deal with

19

the Saturday meeting and I have it from Dr. Rowe's

20

evidence that there were present yourself, Dr. Rowe,

21

was Dr. Carver present?

A. Yes, he was.

22

Q. Dr. Teperman and Dr. Bennett?

23

A. Yes and some police officers.

24

25



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Q. Two police officers?

3

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A. Yes, well I can't remember
who all was there but there were police officers.

5

6

Q. I suppose they were in
civilian clothes, were they?

7

A. Yes.

8

Q. It is always hard to tell
them?

9

A. Yes.

10

11

12

13

Q. I take it, we haven't heard
much mention of it, but Dr. Rowe also mentioned that
there were two people from the Administration of the
Hospital present, including a Miss Lund?

14

A. That is correct.

15

Q. And Dr. Bennett was the Chairman
of the meeting?

16

A. Yes.

17

18

19

20

Q. And the impression perhaps has
been created in my mind that the purpose of this
meeting was to conduct an enquiry into the deaths,
I got that idea in my head, what do you say about
that?

21

22

23

24

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A. No, my understanding of that
meeting, and as I say I did not have the minutes of
that meeting, but my recollection of that meeting was



13

1
2 a meeting between the police, the coroners, the
3 cardiac department, to set up an investigation of
4 these two deaths. I understood that it was an
5 administrative meeting not an involved discussion
6 of the actual details of the deaths of those children,
7 but that is what we were planning to investigate with
8 them.

8 Q. Now I am instructed that Miss
9 Lund sometimes afterwards prepared notes of this
10 meeting and I will make them available to counsel.
11 So I just want to read part of them now and see if
12 you agree with this, and if you do say so, and if you
13 don't don't hesitate to say so.

14 MR. HUNT: I am sorry, what was the
15 date of the meeting?

16 MR. SCOTT: Of the meeting, March
17 21st.

18 MR. HUNT: Of the notes.

19 MR. SCOTT: The notes are not dated
20 but I will undertake to call her if you regard that
21 as useful and to make the notes available to you.

22 Q.
23 "Dr. Bennett chaired the meeting. Dr.
24 Teperman and Dr. Fowler gave a brief
25 review of why the meeting was called.



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"The death of the Pacsai baby caused some concern. Digoxin (something) in the blood just before death were higher than would be expected and when the autopsy was done blood levels were tested and digoxin levels were high again."

Now that is correct so far, isn't it?

A. Yes.

Q.

"Dr. Teperman was notified. He was also informed of high digoxin levels of the Estrella baby who died January 1981.

There was a general question/answer and discussion on the concern all cardiologists have."

Is that correct?

A. Yes.

Q.

"Questions about digoxin blood levels in the literature, medication administration procedures at the hospital, et cetera."

A. Yes.



1

2

Q. Were those things discussed?

3

A. Yes I think that is fair, that
is true.

4

5

Q.

6

"There was a question on how to
proceed to follow up on concerns every-
body had."

7

8

Do you recall that being discussed?

15

9

Q.

10

"There was to be an investigation by
the two officers present, only their
immediate superior was to be told about
the investigation. We were not to
discuss it with anyone. Mr. Murray was
to report back to Mr. Snedden..."

11

12

13

14

15

And Mr. Murray was the other hospital administrator
present?

16

17

A. Yes.

18

Q.

19

"The police requested office space and
were not to be identified as police
only as officers from the coroner's
office. They were to contact myself..."

20

21

22

That is Miss Lund.

23

"...or Mr. Murray on Monday March 23,
1982. It was the week of school break

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"so we felt it would be quiet and office space would be no problem. Meeting adjourned about 3 or 3:30 p.m."

Were those things discussed?

A . Yes.

Q. And did you have any understanding from that meeting about whether the police were undertaking an investigation following what was discussed in the coroner's office on Saturday afternoon?

A. Yes, that is true. My understanding at that time was that the police were being given an office in the hospital and they were to arrive on Monday morning to begin their investigation.

Q. And do you recall them giving you certain instructions as to how they were to be described as this memo reveals, they were not to be described as policemen but rather coroner's people?

A. I don't remember that detail.

Q. Did you believe that as of that time, Saturday afternoon at 3 o'clock, the police had an investigation in hand?

A. I assumed that was the case because we had the conference.

Q. Do you recall being told, as Miss Lund said, that you were not to discuss the



Fowler, ex.
(Scott)

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police investigation with anyone?

3

A. I don't remember that

4

specific warning.

5

THE COMMISSIONER: What are we going
to do with those notes?

6

7

MR. SCOTT: Do you want me to put
them in subject to proof, I would be delighted to
do so.

9

10

THE COMMISSIONER: Yes, I think so.
I think we will just use our own facilities to get
copies for Monday morning I think unless you need
them over the weekend.

12

13

MR. YOUNG: May I just enquire of
Mr. Scott was that the entire contents of the notes?

14

15

MR. SCOTT: No I have two pages of
notes that run from March 21, 1981.

16

17

THE COMMISSIONER: I think we will just
put them in and just hand them to Mr. Young and you
can examine them.

18

19

MR. YOUNG: Thank you.

20

THE COMMISSIONER: What number please?
That will be Exhibit 183.

21

22

---EXHIBIT NO. 183: Notes of Miss Lund taken at
conference held on March 23rd,
1981.

23

Q. Doctor, did you believe the

24

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police had the investigation in hand at that meeting?

3

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5

A. I had the assumption that now that we had the meeting and that they were to move in that they were responsible.

6

7

Q. Well I won't ask the next rather pejorative kind of question that my friend Mr. Percival asked, we will just leave that.

8

9

Now one other matter, Mr. Labow asked you some questions about Kristin Inwood.

10

11

12

13

14

A. Yes.

15

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Q. And that was the case you will recall in which the incident report was filed with the feeling that there was an administration, an improper administration of digoxin?

A. Yes.

Q. Do you recall that?

A. Yes.

Q. And he asked you to say, and I think you agreed, that in light of that improper administration of digoxin; and I just want to see if I understand the answer you gave to him?

A. Yes.

Q. That you would be obliged to regard digoxin now as a possible cause of death, is that the answer you gave to him?



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Fowler, ex.
(Scott)

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A. That is the answer but I
wasn't aware of the timing and other things that are
necessary.

Q. Let me give you the timing.
The record before this Commission will reveal that the
improper administration of digoxin occurred on March
12th at 5:30 a.m.

- - - -



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The record reveals that a digoxin level was ordered on March 12th at 6:00 a.m, one-half hour later. The record reveals that the level reported as 2.6 at 9:00 a.m., three hours later.

A. Yes.

Q. And the record reveals that the baby died -- one other fact. The record reveals that there was no other digoxin as far as we know.

A. Yes.

Q. Administered following that.

MR. TOBIAS: Was the sample taken, Mr. Scott, at the time that the level was ordered.

THE WITNESS: No.

MR. TOBIAS: What time was the sample taken?

MR. SCOTT: The sample was ordered on March 12th at 6:00. I'm not clear whether the record says whether it was taken at 9:00 a.m. or whether the result was revealed at 9:00 a.m.

MR. LAMEK: Let me help my friend, Mr. Commissioner, because it records the hour of collection at 9:00 a.m.

MR. SCOTT: Thank you, all right.

Q. And then the last fact is that the baby died, according to the record, at 3:00 a.m.



F2
1
2 on March 13th and I have calculated that to be
3 some 21½ hours after the accidental administration
4 of digoxin.

5 A. Yes.

6 THE COMMISSIONER: Just a moment,
7 he died when?

8 MR. SCOTT: At 3:00 a.m. on March
9 13th.

10 Q. I have calculated that to be
11 21½ hours after the accidental administration.

12 Now, in light of those facts which so
13 far are proved here, what do you say about whether
14 digoxin toxicity should be considered at that time
15 as a cause of the death of this baby?

16 A. No, I think it very unlikely
17 for several reasons.

18 Q. Yes.

19 A. You tell me in the first place
20 that the patient in whom the accidental administration
21 was actually intended was a small infant by the name
22 of - I can't remember who it was but she is a small
23 infant, Manojlovich, and I'm not sure what ---

24 Q. I said Inwood, I think it was -
25 it was intended for Manojlovich?

A. Yes. So, it was given to
Inwood.



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FF3

Q. Yes.

3

A. But it would be a small

4

dose of digoxin which would be similar to the
5 regular dose for Inwood. So, this would be probably
6 perhaps maybe twice her maintenance dose of digoxin
7 and that in the first place is not severe enough to
8 cause most children any upset at all, particularly
9 if you don't give another dose for some time. The
10 dig. level that was taken was 2.6 nanograms and when
11 we are talking about the therapeutic area for dig.
12 therapy, it is 2 to about .6 or 7 or, say, between
2 and 1.

13

Q. So, the first thing you deal
14 with is the size of the dosage?

15

A. Yes, which is not very much.

16

Q. The second thing you deal
17 with is the reading itself.

18

A. Yes.

19

Q. Which is?

20

A. 2.6.

21

Q. 2.6.

22

A. And that level taken only

23

three hours after the dose was given would ---

24

THE COMMISSIONER: I'm sorry, wasn't
25 it four hours, unless I've got it wrong.

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MR. SCOTT: Three and a half. It was
5:30 a.m.

THE COMMISSIONER: Oh, all right.
Well, there you are, we were each close to right.
Three and a half hours.

THE WITNESS: Three and a half hours.
I'm not surprised at all that the level was slightly
elevated and had you waited for six hours or more
when you should have taken that dose it would
probably be well within the therapeutic range. So
that I think with that extra information that you
have supplied to me I would not think of dig.
intoxication in this case.

MR. SCOTT: Q. Well, it is gilding
the lily but does the fact that the death occurred
some 21½ hours later play any part in your determina-
tion?

A. Oh yes, I think that is very
important as well.

THE COMMISSIONER: It is painting
the lily not gilding ---

MR. SCOTT: Almost finished.

THE COMMISSIONER: Yes. No, it's
all right.

MR. SCOTT: Q. You were asked this



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morning and this afternoon by my friends who act for
parents about a number of babies: the Gionas baby,
the Inwood child, the Turner child, the Murphy child,
the Lutes child.

A. Yes.

Q. Were you aware, and I take it
in every case your evidence appears to be that as far
as you could judge at the relevant time their deaths,
unfortunate as they were, were consistent with the
clinical cardiological status of the children?

A. Yes, that's true.

Q. Were you aware that Dr. Nadas
had in every one of those cases come to exactly the
same conclusion that their deaths were consistent
with clinical status?

A. I must admit that I haven't
read Dr. Nadas' report.

Q. All right. Now, you were also
asked about the Hines baby. Were you aware that
Dr. Nadas of Boston Children's Hospital agreed that
the death of the Hines baby was not only consistent
with its clinical status but was expected. Were you
aware of that?

A. I was not aware of that but
it makes me feel better.



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MR. SCOTT: Those are all the
questions I have, thank you, Doctor.

4

THE WITNESS: Thank you.

5

6

THE COMMISSIONER: All right, thank
you. Ms. Chown?

7

RE-EXAMINATION BY MS. CHOWN:

8

9

Q. Dr. Fowler, you will be
pleased to hear I expect to be very brief with you.

10

11

You have told us understandably that
for you the events that happened on the weekend of
March 21st, 22nd, were very upsetting.

12

13

A. Yes.

14

15

16

Q. And that was not only because
of the death that occurred on that weekend but also
because of your involvement in meetings with the
Coroner and with the police.

17

18

19

20

A. Yes.
Q. You also told us with respect
to the Hines baby that the letter that you wrote to
the parents initially after the baby's death was
written on March 17th.

21

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Q. And if we use our calendar
sense that is just some four days before this weekend
we have been talking about?



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A. Yes.

Q. And following that weekend,
as you have indicated to Mr. Scott, the police
investigation commenced.

A. Yes.

Q. That was to your understanding?

A. Yes, that's true.

Q. You will recall this morning
Mr. Tobias put to you some questions as to follow-
up that you might have done with respect to the
conduction studies and further studies referred to
in your letter of March 17th?

A. Yes.

Q. And I believe he said to you,
or put to you that you in fact did nothing to follow
up on those studies.

A. Yes.

Q. Do you recall that?

A. Yes.

Q. Can you tell me, Dr. Fowler,
what effect the commencement of the police investiga-
tion on - well, really the first meeting on the 21st,
but the formal investigation on the 23rd had on your
access to information within the Hospital?

A. It was almost impossible to



FF8

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receive any information, the charts and all other material related to the patients that we were investigating were not available to us for further review.

6

7

Q. And was there any effect as well on your ability to contact the parents?

8

9

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A. No. No, we were not able to discuss these things with the parents because the coroner's office had all the information and they did the communication with the parents.

11

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Q. I believe you also indicated to Mr. Tobias that you could not recall at this time whether you in fact had seen the preliminary or final autopsy report with respect to Jordan Hines prior to your letter of March 17th.

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A. Yes. No, I'm sorry, go ahead.

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Q. And did the police investigation have any effect on the normal course of events of these reports, these autopsy reports being forwarded to you.

A. I think this probably had some retarding effect on them getting back to my office.

MS. CHOWN: Thank you, Dr. Fowler.

THE COMMISSIONER: Thank you,

Ms. Chown. Mr. Lamek?



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MR. LAMEK: Mr. Commissioner, I'm
afraid I will be a little time. Do you want me to
start now? I am perfectly prepared to go on if that
is your wish, sir, rather than bringing Dr. Fowler
back on Monday.

THE COMMISSIONER: Well, when you
say a little time?

MR. LAMEK: I will be a half an hour.

THE COMMISSIONER: Well, what do you
say, Doctor?

THE WITNESS: No, I would much
rather stay.

THE COMMISSIONER: I think he's got
the veto, so, let's proceed.

MR. LAMEK: Frankly I think that
would be my preference as well, sir.

RE-DIRECT EXAMINATION BY MR. LAMEK:

Q. Dr. Fowler, you referred in
the course of responding to Mr. Scott's questions to
certain experimental situations of which you said you
had read in which dosages of digoxin were administered
to patients and immediately samples were drawn for
digoxin assays?

A. Yes.

Q. And that I take it as you



FF10

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understood those things was to plot the distribution
pattern and rate the digoxin after dosage.

4

A. Yes.

5

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Q. And is it your recollection
that the levels recorded in those experimental
situations were not greater than 9 or 10 nanograms?

7

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A. I can't recall the specific
paper and I thought that they were in that sort of
level, perhaps a little bit more than 10, but that
is a very unusual situation and Mr. Scott was talking
about ---

12

Q. An unusual situation.

13

14

15

16

A. An unordinary patient that
occurred with a high level. But nevertheless, I
think that they can rise to about that level but
I could be corrected.

17

18

19

Q. Well, Dr. Fowler, I certainly
don't intend to ask you any more about that but I
would ask you if you would do this for me, please.

20

21

22

23

24

25

A. Yes.

Q. If you can lay your hand upon
that paper, could you perhaps give it to Mr. Ortved
or Ms. Chown so they can let me have it?

A. Yes.

Q. Thank you very much.



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FF11

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4

Now, the other 9 or 10 nanogram levels that you have seen in your own experience, have those been levels in sick children, patients on the ward?

5

6

A. Yes, these are patients almost invariably who are sick patients whose renal function is affected because of their severe disease.

7

8

Q. Yes, or may have some electrolyte imbalance or something of that sort?

9

10

A. Yes, yes.

11

12

13

14

15

Q. Yes. Can I go back to the comment in gest, and I am sorry to refer to it that way but I undersand your evidence on it. If I may say so, we saw Mr. Scott smoothly induced confusion of that whole situation, if I can put it that way. Let's really plot what happened on that thing, Doctor.

16

17

18

19

20

You think it was not upon the occasion of your investigation of the dosage administered to Pacsai that you made the comment about, do you know anyone who is so imbalanced as to do this kind of thing?

21

A. Yes, yes.

22

Q. You think it was on some other occasion?

23

24

A. Yes.

25



F12

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Q. But you are clear it was a
comment made in gest?

4

A. It was.

5

6

Q. Yes. And I put it to you
therefore that was not likely after the meeting of
March 21st, was it?

7

8

A. I think it would - as you know,
I don't know exactly when it was but it would be
reasonable to think that perhaps it was prior to that
meeting.

10

11

12

Q. Yes. Because after March 21st
you didn't regard this as a joking matter at all,
did you?

13

14

A. You're right.

15

16

Q. And therefore you would not
be making gesting comments after March 21st, would you?

17

18

19

A. That's right.

20

21

Q. And indeed it would probably
be before the Miller digoxin levels were known, would
it not, because as soon as those levels came to you
on the evening of March 20th.

22

23

A. Yes.

24

Q. I'm sorry, the 21st.

25

A. Yes.

Q. You were very upset?



FF13

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A. Yes.

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Q. I suggest too, Doctor, the

4

remark was made also prior to your report to

5

Dr. Carver, which is dated March 20th.

6

A. Yes.

7

Q. And I suggest that for this

8

reason: as we said in your examination in chief,

9

as you traced down the various possible innocent

10

explanations of that Pacsai level.

A. Yes.

11

Q. And as those doors were

12

closed off, one after another to you, so the

13

possibility of something more sinister must have

14

loomed larger and larger, must it not?

A. Yes, that's true.

15

Q. And therefore by the time

16

you came to write your report to Dr. Carver, at some

17

time on March 20th, that wasn't a joking matter either

18

and it was now a possibility that you were forced to

19

face, was it not?

A. I'm afraid even at that time,

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because of the fact that I'm not an experienced

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investigator I still thought that there may be some

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innocent explanation for this happening and I really

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didn't feel that it was really within the realms of

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possibility that this might be an intentional sort of
overdose of dig.

Q. Doctor, I understand and
believe me I sympathize completely. One way of dealing
with the unthinkable is to make a joke about that.

A. Yes.

Q. And I understand that, it is
a way people deal with tension. But I suggest to you
is it not likely that that remark however prompted
and however motivated was made in the course of the
period between the 18th when you learned of the
Pacsai results and the time you finished your report
to Dr. Carver on the 20th?

A. Well, as I mentioned when I
discussed this before I don't remember the precise
time and I think that it is very difficult for me to
say that it is likely at that time but I suppose that's
possible.

Q. Okay, Doctor, thank you.

Now, you also said in the course of
cross-examination that, and I think this is in
response to Mr. Strathy's questions.

A. Yes.

Q. That you were not sufficiently
concerned about the Miller death at the time it
occurred.



FF15

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A. Yes.

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Q. That is to say in the early

4

hours of the morning of the 21st.

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A. Yes.

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Q. To raise a hue and cry. That

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was your language, do you remember?

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A. Yes, yes, that's true.

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Q. But, Doctor, that was the

eighth death on the ward that month was it not?

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A. Yes.

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Q. The ninth if you include

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Kevin Pacsai.

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A. Yes.

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Q. And we now that somebody was

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concerned enough to raise a hue and cry in the sense

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that they immediately had samples drawn for digoxin

assay?

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A. Yes.

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Q. Have you ever asked yourself

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what caused someone else to have sufficient concern

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to do that at the time that baby died.

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A. Well, all I can say is that

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that was someone else's assessment of the situation

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and it was, I can't, I don't know what their reasons

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for doing it is, but naturally someone else was

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involved in it might well have been one of the pathologists, but I did not know who ordered that. They were perhaps looking at the whole situation that we were faced with from a slightly different point of view and this may be the reason they decided to order the digoxin level.

Q. I understand from what you just told Mr. Scott that you did not, at the time you heard about Allana Miller's death by way of a telephone call from, you think, Dr. Schaffer?

A. Yes.

Q. In the early hours of Saturday morning?

A. Yes.

Q. You did not at that time consider it a matter that should be reported to the coroner?

A. That's correct. And the evidence of that is that we didn't do that and it is not a specific memory of that particular telephone call.

Q. Dr. Fowler, do you recall being interviewed by Sergeant Warr on the morning of May 13th, 1981 in your office at the Hospital and discussing with him the Miller death?



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THE COMMISSIONER: May 23rd, was it?

MR. LAMEK: May 13th, 1981, sir.

THE COMMISSIONER: Oh, May 13th, oh,
yes.

THE WITNESS: Yes. I must have had
a, you know, made a statement at that time, so, I
guess I must have discussed this with him.

MR. LAMEK: Q. Well, I cannot tell
you, sir, that I have a copy of a statement signed
by you. I have a note made by Sergeant Warr, and
in due course I will have to call him to put to him
whether this be an accurate note, but I tell you, sir,
that the note records - you said:

"In the early morning hours of March
21, 1981 I was called by Dr. Schaffer
I think to tell me that Allana Miller
had arrested and had died and that they
had been unable to resuscitate her.

He told me that he had got permission
for a post mortem.

The next development was that we weren't
aware of her dig. level but because of
Pacsai and Estrella we decided to talk
to the coroner.

It was decided with Dr. Carver and



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"Dr. Rowe to have a meeting in
Dr. Bennett's office."

Do you recall saying that to Sergeant
Warr some seven weeks after the events in question?

A. I don't remember that actual
chronology but I guess perhaps he's correct in
putting that down. I don't remember though the timing.

Q. Well, Dr. Fowler, does it now
assist your recollection as to whether there was
discussion of reporting Allana Miller's death to the
coroner before the digoxin levels became available?

A. Well, I looked - I don't
remember and I don't remember the specific conversation
but the chart says that I presume was filled out by
Dr. Schaffer that the coroner does not need to be
notified.

Q. Yes.

A. So, there must be some - unless
someone else filled out that death notice that
occurs with every death in the Hospital.

Q. Well, Dr. Fowler, may I at
least have it that if in due course Sergeant Warr
should indeed say that he has recorded what you
told him accurately?

A. Yes.



FF19

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Q. That your recollection as at mid-May, 1981 as to the events surrounding Allana Miller's death would be a good deal fresher than it is now?

A. I would have to agree with that.

MR. LAMEK: Mr. Commissioner, I will deal with that as you please, mark it for identification or whatever. It would probably be appropriate in the circumstances to mark it as an exhibit.

THE COMMISSIONER: I don't think we need to mark it, you've read it.

MR. LAMEK: Then I'm content and I will put it Sergeant Warr in due course.

THE COMMISSIONER: Yes.



G/EMT/ko

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Q. Well, Dr. Fowler, we know that somebody was sufficiently concerned, as we have said, to order samples drawn on that baby at the time she died?

A. Yes.

Q. And we know because he has said so that Dr. Rowe was very concerned when he heard of the death of Allana Miller?

A. Yes.

Q. And you have told us that at the meeting on 21st, Mr. Scott read those notes to you --

A. Yes.

Q. That one of the matters discussed was the concerns of the cardiologists?

A. Yes.

Q. Do you remember that?

A. Yes.

Q. Was Allana Miller not one of the concerns of the cardiologists at the time of that meeting?

A. Well, there is no evidence that we discussed her case at that meeting, and so my memory of that meeting is dim at this time. So I can only assume that we didn't discuss her at that time.

As has been pointed out on a couple of



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occasions this afternoon, however, it was an
investigational meeting or an administrative
meeting to get the wheels going for the police
investigation as well.

Q. Yes, I understand that.

A. And this may be the reason that
we didn't get down to specifics and talk about specific
cases.

MR. LAMEK: Was the note with the
minute marked as an exhibit?

THE COMMISSIONER: Yes it was. Exhibit
183.

MR. LAMEK: Can I borrow it for a
minute, please?

Q. The note, as I understand it
from what Mr. Scott said, and also I confess from the
name that is written at the top of the first page, is
that of Marie Lund --

A. Yes.

Q. -- who is on the administrative
staff of the hospital?

A. Yes, at that time.

Q. And the note records, as I think
Mr. Scott may have read,



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"There was a general question, answer

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and discussion on the concerns the

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cardiologists had. Questions about

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digoxin blood levels in the literature,

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medication, administration procedures

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at the hospital, etc."

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What were the concerns that the

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cardiologists had as at the afternoon of March 21st,

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1981?

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A. The concerns, of course, were

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Pacsai's death with high levels. The linking of those

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with the levels of Estrella which were again brought

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up as a possibility that these indicate something

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because prior to that meeting I had not thought of

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Estrella, and again at that meeting the two cases

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were discussed again together. And naturally we felt

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that further investigation would be needed.

19

Our concerns were naturally that it is
conceivable that there was an accidental or intentional
overdose of digoxin involved in these two patients.

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Now I don't remember a review of all

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the patients in the hospital where there were strange -

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or the fact that there were so many babies dying in

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a short period, and I don't remember the substance of

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the particular concerns that we discussed, but I would

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assume this would be the thing.

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Q. You at least are clear,

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Dr. Fowler, that as at that time the death of Baby
Miller was not a concern to you?

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A. No. Until I had received the
digoxin level.

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Q. It was not a matter of any
apprehension to you that perhaps this was another
child in the pattern of Pacsai?

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A. Well, I can't remember whether
that was in my mind or not.

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Q. Doctor, I am interested in the
evidence that you gave a little earlier to Mr. Tobias,
and believe me I am not going to ask you to provide
me with copies of any of these things.

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I am interested, though, in knowing
the method, the system, by which the various cases
were discussed between the cardiologist group in
preparation for these hearings.

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You have adverted to it and I confess
this is the first time I have heard about it. I am
a bit interested in just what happened.

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Can you tell me just who participated
in the process?

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A. The Big Six on the staff who had



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any relation to - these were people who were on the
staff at the time.

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Q. That would be Dr. Rowe?

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A. Yes.

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Q. Yourself?

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A. Yes.

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Q. Dr. Freedom?

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A. Freedom.

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Q. And Dr. Vera Rose?

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A. Vera Rose.

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Q. And Dr.?

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A. Peter Olley.

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Q. Peter Olley.

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A. And Dr. Izukawa.

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Q. Izukawa?

17

A. Yes.

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Q. And can you describe for me,

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please, what was the process that you went through?

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A. We had a list - I don't know

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whether the number of patients that were going to be
considered at the hearing was given to us or I am not
quite sure about that, but we had a list of I guess
36 patients that we thought - there might have one or
two more.

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Q. Yes?

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A. But that was the list of the patients that we thought would be likely the subject of this hearing.

Q. Yes.

A. And it was decided with our Counsel that the most efficient way to deal with this monumental task of trying to assimilate all the medical facts was to divide up the load of going through the charts in detail among the six of us.

And Dr. Rowe with Mr. Ortved made a two page summary which I referred to several times here with key things that we felt were going to be very important at this hearing: things like who was on call.

Q. Sort of a check list?

A. And what time the child died and where was it, and this sort of thing.

- - - -



EMT.jc
GG2-1

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Q. Sure.

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A. In the front with the summary

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of the post mortem results, and then each person would

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go to the charts and we got the key to the record

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room, and there was a great flurry for some weeks,

7

people going down between patients and so on, taking

8

out these charts, digesting everything that was in

9

them, writing down a summary of what was thought at

10

that time to be the key data --

11

Q. Yes.

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A. -- in that patient.

13

Then that was Xeroxed to the whole

14

six of us and we had several meetings - because there

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were many patients would be known to several other

16

people, we went through every patient, the six of us,

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and made sure.

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Then we added things and changed

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things a little bit to make sure that this was a

20

consensus of what we thought was the key problems

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In addition we had a summary of

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Dr. Bain's assessment, a summary of what we thought

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when the child died, and the final little note at

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the bottom what we think now.

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We then did this with every one of



GG2-2

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the cases, and then we thought our work was done for the time being, and then Dr. Rowe came back and he said we have to get a picture, a diagram of every one of these babies, so we did the whole thing again. Got out the charts, got the hemodynamic data, the angiograms and everything else and came up with those very beautiful I must say line diagrams, and I am sure that as laypeople you found it was very easy, with a great teacher like Dr. Rowe, to show you what was going on.

11

12

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Q. Dr. Fowler, they were enormously helpful, and I wish I could take the credit for having thought of it. I can't.

14

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Do I understand that each of you took what, six or seven of these charts and prepared a summary?

16

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A. Yes. Actually I took a few more than some of the others because I was unfortunate enough to be involved in a little more patients than others, but that was more or less what it was.

20

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Q. The distribution of charts for review and summarization took account of who had been involved?

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A. Yes. We tried to give it to the person that had the most --

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Q. Who knew the most about it?



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A. Yes. But as I say, it was a joint effort, and perhaps from the legal point of view this kind of committee type of analysis of things is perhaps not acceptable, but it was the only way to do it.

Q. Doctor, rest assured that as far as I am concerned, speaking only for myself, I think it is a very sensible way of doing it, and I take it that it provided you, if there were consensus about a particular child --

A. Yes.

Q. -- with the comfort of knowing that other people, bright experienced cardiologists were of the same mind that you were?

A. Yes.

Q. The only thing that bothers me is that I would have to be sure that any dissenting voice were heard from.

Do you recall any situation where any member of the group dissented from what would otherwise be a consensus about a child?

A. Oh, I think this must have occurred on a few occasions, but as you know we get along very well, and we sort out our difficulties and I think that eventually we would say that this is our assessment of what was going on.



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Then of course the reason for doing all this was to then present this to Dr. Rowe, who then of course agreed under the suggestion of our counsel to be the one who would go through everything here and he has done an excellent job. And then has made it very much easier for the rest of us.

Q He did except for this problem that I have, Dr. Fowler.

A Yes.

Q It is not your problem yet. It may become your problem.

If there is a dissenting voice or a divergence of opinion about any chart, are you telling me that I am not going to discover that unless I happen to call the person who holds that view and ask the express question about the particular child.



GG3.1

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A. Yes, I think that is true.

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The person, however, that you are likely to call is the person who was most identified with that patient, and that he would present his own personal view.

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In other words, when you are sitting here you have to answer for your own assessment of that patient.

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Q. That is right.

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A. And you well imagine we have our little summaries, but we go back then if we know we are going to talk about a certain patient and go back to the original charts again and personally go over it, and here again I suppose we might have some difference in the analysis there, and of course when we are the witness we present our assessment.

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Q. I confess, doctor, I have no difficulty whatsoever with a consensus opinion of a group of cardiologists if it truly be a consensus.

18

A. Yes.

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Q. But I have a little trouble with the idea that I have to dig out any possible area of divergence, and that obliges me to ask this rather blanket question I'm afraid: I asked you about some 19 of 36 children.

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A. Yes.

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Q. You have read Dr. Rowe's evidence. He gave evidence about an additional 17 children.

A. Yes.

Q. Do you recall any of those other 17 children with respect to any of whom you have a divergence of opinion or view from that expressed by Dr. Rowe?

A. No. No, I don't. And as you well would imagine we discuss the patients and what happens in this courtroom every afternoon with him or we would meet in his office for half an hour.

Q. Yes.

A. So that --

Q. Okay. Well, as long as I can be satisfied that I am hearing all the shades of opinion on this and not, forgive me, I don't mean to be pejorative, the party line.

A. Yes.

Q. Then I am content with the approach you have taken. I have no criticism of it.

THE COMMISSIONER: Was there any suggestion that you should agree? Was it a policy that you are going to try and get an agreement, to get a consensus, if you like, and put that forward?



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THE WITNESS: No. No, I think what we were simply trying to do was arrange a huge amount of medical data in a way that could be handled by people, I don't think there was any suggestion at all that you couldn't disagree with the majority opinion. But it is very difficult for me to remember any case in which there was marked discussion as to whether this really was a problem that a child died of his disease or there was some other factor.

MR. LAMEK: Q. Dr. Fowler, when did the process, the review process you have described, begin?

A. Well, I suspect that it began when we knew the dates of this hearing.

I think that our counsel was actually the one to suggest that this might be an efficient way for us to attempt to deal with this overwhelming problem because, of course, many people here are just -- we are doing this work, we are trying to carry on with the medical practice at the same time.

Q. Doctor, I understand the problem and the exigencies of other demands and so on, but I say for myself I have no difficulty with the system that you adopted.

A. Yes.



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Q. I do confess it would have been very much better had I known about it from the beginning. But at least I know about it now.

Having begun the process that you have told me once you knew when these hearings were to take place, do you have any recollection how long it took for the review of the charts to go ahead and the meetings to take place to discuss them?

A. Oh, I would have no idea how long that took.

Q. All right.

A. It was a burden, I can tell you, on top of our other work, but I can't tell you exactly how many hours.

Q. I can assure you I sympathize with that. Unschooled, I did 36 of them.

Can I ask you a question of Kevin Pacsai, please?

A. Yes.

Q. In the course of his cross-examination Mr. Tobias asked you about the apparent failure to follow up with respect to the study of the conduction system.

A. Yes.

Q. Sorry, it was Hines, wasn't it? That Dr. Becker had apparently suggested --



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A. Hines, yes.

Q. Do you know if the heart of Kevin Pacsai was available to the Hospital to be studied after the weekend of March 21st?

MR. TOBIAS: I believe you are referring to the heart of Jordan Hines.

MR. LAMEK: I'm sorry, Jordan Hines.

A. Yes. I think it is not, but I cannot be sure.

THE COMMISSIONER: You think it is not?

THE WITNESS: I think it is not, and I am not positive about that, but I think that the Coroners -- I am not positive but I think that they have some of the heart tissue as well.

MR. LAMEK: Q. You have no information?

A. But I have no information about that.

Q. And even if it is now with the Coroner or the Centre for Forensic Science you don't know when it went there?

A. No.

Q. Questions were asked of you



1
2 about any anomalies in the electrocardiogram of
3 Jordan Hines.

4 We were talking about a prolonged
5 QT interval and that sort of thing?

6 A. Yes.

7 Q. I do have from a copy of
8 the contents of the Zebra Pack for Jordan Hines. Inso-
9 far as I can see, Dr. Fowler, the only thing it
10 contains that was not in the chart, some rhythm strips.

11 A. Oh, yes.

12 Q. I wonder if they would be
13 helpful to you. Could you cast a glance at those
14 because the evidence this morning was there is no
15 evidence of such an anomaly --

16 A. Yes.

17 Q. -- in the electrocardiogram
18 of Jordan Hines.

19 A. Yes.

20 Q. And fairly to you, you
21 should be able to satisfy yourself from the strips in
22 the Zebra Pack.

23 First, are you able to tell me that
24 you recognize the documents I have given to you as
25 the contents of the Zebra Pack of Jordan Hines?

A. Yes, they look like -- Yes, I



GG3.7 1
2 am sure they are because his name is inscribed at
3 the top.

4 Q. Thank you.

5 MR. TOBIAS: I take it you are
6 making that an exhibit at this time, are you?

7 THE COMMISSIONER: Yes. It is
8 helpful but I wonder --

9 MR. LAMEK: Yes, please.

10 THE COMMISSIONER: Well, I guess we
11 had better make it an exhibit.

12 MR. LAMEK: Once again it could be
13 appended by a letter to the number of the chart
14 exhibit, which was 103. I think we have an Exhibit
15 103A.

16 MR. TOBIAS: Yes, final autopsy
17 report.

18 MR. LAMEK: Perhaps it could be
19 103B.

20 THE COMMISSIONER: 103B.

21 MR. LAMEK: Thank you, sir.

22 --- EXHIBIT NO. 103B: Electrocardiogram, Jordan
23 Hines.

24 THE WITNESS: On the electrocardio-
25 grams that I see here, I don't see any evidence of
a prolonged QT interval. There are some abnormalities



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in the electrocardiogram, and I'm sure they were pointed out before.

The other thing, of course, is that we have a rapid heart rate, and then the next strip is a very slow heart rate and then again it is going very fast, so this is the tachy/brady type of arrhythmia that he was sent in to the Hospital with.



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Q Okay, Dr. Fowler, at least I have
it now, that on all of the rhythm strips that appear
to be available --

A. Yes.

Q -- in either place where you
would expect to find them --

A. Yes.

Q -- you are now able to tell us
that you don't see the QT prolongation?

A. Yes, that is true, the prolongation
that you sometimes see.

MR. OLAH: Mr. Commissioner, is there
any way of determining when these rhythm strips were
taken, perhaps the witness can assist us with that?

THE WITNESS: I am sorry about this,
but one of the problems with rhythm strips is that
most of the identification is on the back and of course
this is a copy and you have to have the original strip
to see and many times people write the hour and the
time and so on, but there is no identification here
as to what time that - there isn't even a date on
here. So I think there is no way one could say what
time that occurred, but the next one of course is not
a rhythm strip, it is an ordinary electrocardiogram
which is dated with the time.



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MR. LAMEK: Mr. Commissioner, if we could look at the back of the original record we will do so.

MR. TOBIAS: Did I understand the doctor to say there was a date and time or just the day?

THE WITNESS: No day.

MR. TOBIAS: I am sorry.

THE COMMISSIONER: 6.3.81.

THE WITNESS: Yes.

MR. OLAH: That would seem to coincide with the admission date. Perhaps the doctor might be able to instruct us as to whether that would be the time of admission or initial consultation?

THE WITNESS: Yes, I would have expected virtually every patient who comes into the cardiac service has an electrocardiogram within 24 hours, as soon as there are technicians available to have that done.

The rhythm strip, if they came from our Hospital, might well have been taken subsequent to that, but if he had an irregularity in the heart rate - if he came in in the evening they might have been done prior to the formal electrocardiogram that you could see that is dated.

MR. LAMEK: Q Just one other very



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small matter, Dr. Fowler, if I may. You will be glad to know that I have drawn a line through all sorts of other things that I thought I might ask you but they are unimportant.

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You told Mr. Strathy that with respect to the Estrella digoxin level when you received it some time in March.

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A. Yes.

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Q. As contained in the autopsy report, that one of the things that encouraged you to disregard it, if you will, was that the pathologist apparently hadn't regarded it as vital and very important, he hadn't raised again, and the immediate words were "a hue and cry" about it?

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A. Yes.
Q. Was that something that occurred to you when you first saw that Estrella level, that the pathologist doesn't seem very excited, why should I be?

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A. Well, that certainly occurs to me.

Q. Did it occur to you then?

A. At that time?

Q. Yes.

A. At that time I think the most striking thing that occurred to me was that I can't believe this level.



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Q. Yes.

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A. Then I thought well, this was done several months before so that obviously a person who received the report from Biochemistry also had this opinion.

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Q. And you have a recollection that that was part of your response at the time?

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A. Yes.

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Q. And I take it your comfort level therefore in not attaching any weight to that level yourself was enhanced by that observation that the pathologist hadn't gotten excited about it?

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A. Yes. But, as you know from the evidence I was concerned enough to discuss it with Dr. Rowe.

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Q. Yes.

A. Because I think he has that in his evidence that he also saw this from the time I did, and he also had the same feeling about it.

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Q. And Doctor, I don't mean to be facetious, but neither of you were so concerned as to follow up on any inquiry about it?

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A. Well, I think that this is very vague in our memory, because it was my understanding that we were going to discuss with Dr. Freedom a



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further assessment of this rather strange thing and he wasn't at the Hospital at the time. But subsequently I think he told us that I think, that he was aware of this level even perhaps a little before we were and that he had the same sort of response to it.

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Q. I don't mean to have you repeat your evidence on that point. My question is this, having taken some comfort in the fact that the pathologist didn't get all excited when he saw that number, was your comfort level reduced when on March the 20th it was the pathologist who decided that case had to be reported to the coroner?

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A. Well, of course I think logically the reason that he decided to talk to the coroner is that he got another one. I mean, you can't have an epidemic of one, and we got another level that was available at that weekend and the instant there was one definite abnormality, and one that was thought to be not reasonable, but another one came along that was beyond the usual sorts of levels that we see even in sick children, that he put these two things together and decided that we should discuss it with the pathologist.

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Q. So certainly it appears that Dr. Mancer did put together, and we will ask him about



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it, the two readings that neither you nor Dr. Freedom
or Dr. Rowe put together?

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A. Yes.

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Q. But my question was, upon
discovering that the pathologist was now raising a
hue and cry about that number by reporting that case
to the coroner, did that reduce your comfort level
about that number?

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A. Well, I think you are right.
Now, this was out of my mind until the two things
were brought up simultaneously, and then naturally
I was concerned, that is why we were concerned at the
conference that we had with the pathologist.

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Q. Dr. Fowler, it has been a long
day, you have been a little longer than we thought
you would be.

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Thank you very much.

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THE COMMISSIONER: Thank you, Doctor.

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MR. HUNT: I have a comment, Mr.

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Commissioner.

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THE COMMISSIONER: Yes, all right.

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MR. HUNT: There has been some
new material raised by my friend in his re-examination
about this consensus approach to the evidence with
respect to these deaths.



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Now frankly I have some questions about that, I am in a bit of a state of confusion exactly as to how this works in terms of what the evidence we are getting is.

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THE COMMISSIONER: Well, does it help you to know that Dr. Rose is the next witness?

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MR. HUNT: Well certainly the same things can be asked of Dr. Rose.

THE COMMISSIONER: Are there any other cardiologists to be called from Sick Children's Hospital?

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MR. LAMEK: Yes, I am proposing to call two of the remaining three, that is Dr. Rose and Dr. Izukawa. Maybe in light of this I may have to call Dr. Olley which I had not proposed to do.

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THE COMMISSIONER: They were all involved, all six, isn't that right?

MR. LAMEK: Yes, yes.

MR. HUNT: Perhaps I can explore it then.

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MS. KITELY: Mr. Commissioner, I know it is late in the day but I want to follow up on something my friend just said. I have two comments on matters arising out of Mr. Lamek's re-direct examination.



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First of all, he produced that document which I gather is what Mr. Hunt is talking about, the minutes, or the notes of an interview in May, two months later, about events in March.

THE COMMISSIONER: No, he didn't produce that, that document hasn't become an exhibit.

MS. KITELY: He produced it, he didn't make it an exhibit.

THE COMMISSIONER: No.

MS. KITELY: The difficulty I have with that is twofold. First of all, he did it in re-direct after probably half of the counsel here had asked questions about that day.

THE COMMISSIONER: Yes.

MS. KITELY: And if he had that document it is something that ought to have gone in in chief because clearly we went over and over those minutes.

THE COMMISSIONER: No, you don't have to put in a document like that in chief. This was because of something that developed in the course of the cross-examination and he was trying, simply asking him, did you meet at a meeting with the police on such and such a date, did you not say that.

MS. KITELY: But what he was drawing



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his attention to was notes of a meeting that was held
two months after the date ---

THE COMMISSIONER: No, I must be
getting it wrong, what he was drawing his attention
to was an interview between him and one of the policemen.

MS. KITELY: Yes.

THE COMMISSIONER: Yes, that's right.

MS. KITELY: And he put it to the
witness to help him refresh his memory about events
which occurred on March the 21st that we all examined
about.

THE COMMISSIONER: Yes.

MS. KITELY: And in my submission that
was something that if my friend Mr. Lamek had, he
ought to have put it to him in chief. He ought to
have prepared him with it, which brings me to my
second point.

THE COMMISSIONER: No, no, you don't
necessarily have to cross-examine someone - it was
something, I have forgotten, and perhaps you can help
me out, Mr. Lamek.

MS. CRONK: Because of the evidence
given in the course of the cross-examination.

THE COMMISSIONER: Yes, by who?

MS. CRONK: Essentially by Mr. Scott.



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THE COMMISSIONER: So that is what brought it out.

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MS. KITELY: Well, it might have brought it out, sir, but this morning when we had this discussion about the statement?

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THE COMMISSIONER: Yes.

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MS. KITELY: I specifically made the point that I thought statements were obviously acceptable but not notes made by other people. I understood, in fact I made a note that Mr. Lamek indicated that before a witness gets in the stand he gets a copy of everything arising from contacts with the police.

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THE COMMISSIONER: That's right.

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MS. KITELY: Now, it would appear to me that Dr. Fowler had never seen --

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THE COMMISSIONER: That's right.

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MS. KITELY: Now, it would appear to me that Dr. Fowler has never seen --

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MR. LAMEK: With respect, Dr. Fowler and his counsel can speak for themselves.

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Miss Kiteley is impugning what I said and I ask her to withdraw it.

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THE WITNESS: I did receive that and I read it, among all the other documents, and I was -- I forgot that particular sequence. I have seen that before.

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MS. KITELY: If that is the case, then, obviously, I don't mean to impugn my friend.

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It certainly appeared, from the reaction of Dr. Fowler when he was on the stand, but I still stand by the first one; that it ought not be something that would come out in redirect examination.

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THE COMMISSIONER: But it came out because of cross-examination, because something came out in cross-examination which was contrary to this information that Mr. Lamek had. Therefore, he has a perfect right, in re-examination, to go into it.

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MS. KITELY: It is 5:20 in the afternoon of a long week and I don't intend to pursue



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HH3.2 2 it anymore, sir. I simply have concerns about this
3 document coming in at this time.

4 Those are all my comments.

5 THE COMMISSIONER: Fine.

6 Well, I won't pursue it any further
7 either, but at the moment, I am not accepting your
8 submission. So there we are.

9 Now, Mr. Tobias.

10 MR. TOBIAS: I again don't want to
11 delay us any longer than we have already been delayed.

12 Since I have an engagement else-
13 where Monday morning, I wonder if I could get some
14 idea from Miss Cronk how long she intends to be in
15 chief with Dr. Rose.

16 MR. LAMEK: I am not Miss Cronk.

17 THE COMMISSIONER: No.

18 All right. Are you taking the --

19 MR. LAMEK: No. But the present
20 intention, Mr. Commissioner, is to call Dr. Carver
21 first on Monday.

22 THE COMMISSIONER: Yes.

23 MS. THOMSON: Excuse me, Mr.
24 Commissioner, I wonder if the witness might step
25 down.

MR. LAMEK: Oh, yes, of course.

I'm sorry, Dr. Fowler.



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THE COMMISSIONER: The reason why I didn't wish you well and send you off was because I thought there might be some further questions coming, but I don't think anybody is making that proposal now. So, thank you very much, doctor. I think I would make a hasty retreat now before anything else does happen. We may have to carry on here for a while.

THE WITNESS: Thank you.

--- witness withdraws.

THE COMMISSIONER: All right now.

MR. LAMEK: I understand Dr. Carver's availability next week is limited to Monday.

THE COMMISSIONER: Yes.

MR. LAMEK: And, therefore, I propose to lead his evidence on Monday. It may take, by the time all cross-examination is completed, at the most a day. If it takes no more than the morning, then I expect Miss Cronk will be able to lead the evidence of Dr. Rose after lunch, and she can speak for herself as to the time estimate. I would think the whole thing would take one and-a-half to two days.

MS. CRONK: Yes. I would agree with that.



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THE COMMISSIONER: That is your examination?

MS. CRONK: No, that is all evidence. I don't expect to be more than two to two and-a-half hours with Dr. Rose.

MR. TOBIAS: Thank you.

MR. LABOW: Could I ask a question of Mr. Lamek.

Could he outline very briefly what Dr. Carver's evidence will be on and if he is talking about specific children.

MR. LAMEK: No, Dr. Carver will not be talking about specific children. I am interested in Dr. Carver's involvement in these matters from the time he learned of the Pacsai digoxin levels until he met at the Saturday meeting on March 21st.

That is my interest in his evidence and that will be the nature of it.

THE COMMISSIONER: Does anyone else have anything? If not, I will make a hasty retreat and we will meet again at ten o'clock on Monday.

--- whereupon the hearing was adjourned until Monday, the 19th day of September 1983 at 10:00 a.m.

